S. Hrg. 99-520, Vol. II

QUALITY OF CARE UNDER MEDICARE'S PROSPECTIVE PAYMENT SYSTEM

Volume II—Appendix

HEARINGS

BEFORE THE

SPECIAL COMMITTEE ON AGING
UNITED STATES SENATE

NINETY-NINTH CONGRESS

FIRST SESSION

WASHINGTON, DC

MEDICARE DRG'S: CHALLENGES FOR QUALITY CARE
SEPTEMBER 26, 1985

MEDICARE DRG'S: CHALLENGES FOR POST-HOSPITAL CARE
OCTOBER 24, 1985

MEDICARE DRG'S: THE GOVERNMENT'S ROLE IN ENSURING QUALITY
NOVEMBER 12, 1985

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CORRESPONDENCE BETWEEN THE SENATE SPECIAL COMMITTEE ON AGING AND THE DEPARTMENT OF HEALTH AND HUMAN SERVICES

April 26, 1984, letter from Senator John Heinz, Senator John Glenn, Senator Pete V. Domenici, Senator Lawton Chiles, Senator Charles H. Percy, Senator John Melcher to Margaret M. Heckler, Secretary of the Department of Health and Human Services (DHHS) re: concerns about disincentives for quality care under Medicare's Prospective Payment System (PPS).

October 16, 1984, letter from Carolyne K. Davis, Ph.D., Administrator of Health Care Financing Administration (HCFA), DHHS, to Senator Heinz re: mechanisms for monitoring the quality of care received by Medicare beneficiaries (attachment).

November 29, 1984, letter from Senator John Heinz, Senator John Glenn, Senator Pete V. Domenici, Senator Lawton Chiles, Senator Charles H. Percy, Senator John Melcher, Senator Nancy Kassebaum, Senator David Pryor, Senator William Cohen, Senator Quentin Burdick, Senator Larry Pressler, Senator Christopher Dodd, Senator Charles Grassley, Senator J. Bennett Johnston, Senator Pete Wilson, Senator Jeff Bingaman and Senator John Warner to Carolyne K. Davis, Ph.D., Administrator, HCFA, DHHS re: request for more information about proposed revisions to standards and additional questions regarding quality of care for Medicare beneficiaries.

January 29, 1985 letter from Senator John Heinz to Margaret M. Heckler, Secretary, DHHS re: request for additional records and documents regarding the utilization of Medicare and Medicaid services and procedures.

January 29, 1985 letter from Carolyne K. Davis, Ph.D., Administrator, HCFA, DHHS to Senator John Heinz re: proposed conditions of participation in Medicare and Medicaid for hospitals (attachment).

February 12, 1985 letter from Cynthia C. Root, Deputy Assistant Secretary for Legislation (Health), DHHS, to Senator John Heinz re: delay in reply to letter of January 29, 1985 while HCFA awaits opinion of DHHS General Counsel on the disposition of information about the Peer Review Organizations (PRO's).

March 8, 1985 letter from Carolyne K. Davis, Ph.D., Administrator, HCFA, DHHS to Senator John Heinz re: DHHS concerns about control of information on the PRO program provided to the staff of the Senate Special Committee on Aging.

March 28, 1985 letter from Senator John Heinz to Margaret M. Heckler, Secretary, DHHS re: clarification of March 8, 1985 letter from Carolyne K. Davis, Ph.D., Administrator, HCFA, DHHS.

May 28, 1985 letter from Lawrence J. DeNardis, Acting Assistant Secretary for Legislation, DHHS, to Senator John Heinz re: response to March 28, 1985 request for clarification regarding the control of information on the PRO program (attachment).

June 19, 1985 letter from Margaret M. Heckler, Secretary, DHHS, to Senator John Heinz re: General Accounting Office (GAO) preliminary report on the impact of PPS on post-hospital care.

July 24, 1985 letter from Senator John Heinz to Margaret M. Heckler, Secretary, DHHS re: concerns about the monitoring of quality of care under the Medicare PPS resulting from the report of DHHS Inspector General citing cases of premature discharge and inappropriate transfer of Medicare patients (attachment).

July 25, 1985 Comments to Press by Senator John Heinz re: quality of health care (attachments).

August 1, 1985 letter from Senator John Heinz to Margaret M. Heckler, Secretary, DHHS re: commending DHHS for expediting instructions to PRO's regarding the handling of inappropriate hospital discharges and transfers.

August 9, 1985 letter from Carolyne K. Davis, Ph.D., Administrator, HCFA, DHHS, to Senator John Heinz re: HCFA statistics on premature and inappropriate hospital discharges (attachment).

September 5, 1985 letter from Margaret M. Heckler, Secretary, DHHS, to Senator John Heinz re: HCFA, PRO's and quality of care issues (attachments).

October 2, 1985 letter from Margaret M. Heckler, Secretary, DHHS to Senator John Heinz re: response to letter of July 24, 1985 and access of Senate Special Committee on Aging staff to internal documents and meetings with PRO's (attachments).

October 7, 1985 letter from Senator John Heinz to Margaret M. Heckler, Secretary, DHHS re: serious flaws and deficiencies in PPS.

October 10, 1985 letter from Lawrence J. DeNardis, Acting Assistant Secretary for Legislation, DHHS, to Senator John Heinz re: inability of DHHS to comply with October 10, 1985 deadline for information requested in October 7, 1985 letter.

October 17, 1985 letter from Senator John Heinz to Margaret M. Heckler, Secretary, DHHS re: request for appearance at November 12, 1985 hearing.

October 30, 1985 letter from Senator John Heinz to Margaret M. Heckler, Secretary, DHHS re: findings from Senate Special Committee on Aging October 24, 1985 hearing.

October 31, 1985 memo from Hanns Kuttner, Special Assistant to the Deputy Assistant Secretary for Legislation (Health), DHHS, to James Michie, Chief Investigator, Senate Special Committee on Aging re: HCFA release of requested information and documents (attachments).

November 4, 1985 letter from Margaret M. Heckler, Secretary, DHHS to Senator John Heinz re: interim response to October 30, 1985 letter.

November 8, 1985 subpoena issued to C. McClain Haddow, Acting Administrator, Health Care Financing Administration, DHHS, for certain documents to be submitted to the Senate Special Committee Aging on the morning of November 12, 1985 (attachments).

November 8, 1985 letter from C. McClain Haddow, Acting Administrator, HCFA, DDHS, to Senator John Heinz re: modifications to scope of work for PROs.

November 12, 1985 draft of DDHS responses to Senator John Heinz's letters of October 17 and October 30, 1985.

February 19, 1986 letter from Senator John Heinz to Richard P. Kusserow, Inspector General, DDHS re: request for assistance in the Committee's inquiry into the impact of the PPS on quality of care.

PETE V. DOMENICI, N. MEX.
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United States Senate
SPECIAL COMMITTEE ON AGING
WASHINGTON, D.C. 20510

April 26, 1984

Honorable Margaret M. Heckler
Secretary of Health and Human Services
200 Independence Avenue, S.W.
Washington, D.C. 20201

Dear Madame Secretary:

We are writing to express our concerns about the Medicare Conditions of Participation regulations for hospitals currently undergoing final review by the Department of Health and Human Services. As members of the Senate Special Committee on Aging, we are deeply concerned about the quality of health care for Medicare beneficiaries. While we agree that unnecessary and costly administrative requirements for hospitals should be eliminated, we believe that the proposed regulations should be strengthened to protect patient health and safety standards.

With the implementation of Medicare's new prospective payment system, significant changes are taking place in our nation's hospitals. Under the DRG system, hospitals now have incentives to reduce inpatient stays and to perform "efficient" out-placement of patients, perhaps to the detriment of Medicare recipients.

Moreover, we feel the mechanisms that will guarantee the delivery of quality care are insufficiently developed at present. The three major vehicles - a new quality assurance condition, the peer review organizations, and a new Medicare survey form for certification - are all only in developmental stages. Until these mechanisms can be reviewed and tested, we will not know if they are sufficient to safeguard against substandard or inappropriate care. We are concerned, in particular, that the proposed regulations do not answer the following questions regarding quality of care issues:

- How will the new state survey evaluate quality of care, including the performance of duties by trained professionals?

- How often will states be expected to survey each hospital? What steps will be taken to monitor non-compliance with regulations?

- What efforts are planned to train and assist states with the implementation of the new survey system? Are sufficient personnel available to carry-out the certification inspections in light of the staff cuts at HHS as well as in many state agencies?

- How will the PROs verify the appropriateness of discharge planning? What mechanisms will be used to determine that social and mental factors were properly evaluated?

- Will the PROs review the quality assurance programs? Will the new survey system also review this condition and if so, what standards will be used to determine that quality assurance conditions are being met?

To be certain that the new incentives for early discharge and the improvement of hospital management do not compromise the quality of patient care, these proposed regulations should be revised to require that appropriately trained professionals be used effectively in the overall management and discharge of Medicare patients. We further suggest that the Secretary be provided with the authority to waive such requirements where hardships can be shown to occur in the recruitment of particular personnel.

We believe revised regulations can be adopted which will accomplish our desire to both streamline the system of hospital management and also protect the quality of patient care. We hope you will take these concerns under consideration before the regulations are issued in final form.

We look forward to your reply.

Sincerely,

John Heinz
JOHN HEINZ
Chairman

John Glenn
JOHN GLENN
Ranking Minority Member

Pete V. Domenici
Pete V. Domenici
United States Senator

Lawton Chiles
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United,State Senator

Jeff Bingaman
Jeff Bingaman
United States Senator

DEPARTMENT OF HEALTH & HUMAN SERVICES
Health Care Financing Administration

The Administrator
Washington, D.C. 20201

OCT 16 1984

The Honorable John Heinz
Chairman, Special Committee on Aging
United States Senate
Washington, D.C. 20510

Dear Mr. Chairman:

Secretary Heckler has asked me to respond to your letter expressing concern about the proposed Medicare conditions of participation for hospitals which are currently undergoing review within the Department.

Please pardon the delay in my response. We share your concern about maintaining the quality of health care, and believe that this objective will be well-served when surveying hospitals for compliance with the proposed requirements. The proposed revisions were intended to simplify and clarify Federal requirements, to give flexibility in hospital administration while strengthening patient health and safety, and to emphasize results rather than process. In developing these revisions we also sought to promote cost effectiveness while maintaining quality of care.

There has been no substantial revision of the conditions since they were first published in 1966. However, there have been significant changes in the organizational structure of hospitals and dynamic technological advancements since 1966. The conditions must be applicable and relevant to both the smallest rural facility and to the most complex urban hospital center. The proposals we are considering focus on (1) eliminating unnecessary regulations and providing hospitals with greater flexibility; (2) replacing prescriptive administrative requirements with language that is stated in terms of expected outcome; and (3) in most cases, giving responsibility to the hospital for choosing its own staff and delineating staff responsibilities rather than specifying Federal requirements for credentials and qualifications. The proposal revisions strengthen the basic purpose of the conditions, which is to protect patient health and safety by including a new condition of participation that requires the hospital to establish a hospital-wide quality assurance program aimed at identifying and correcting patient care problems.

In conjunction with modifying the conditions we are studying revisions of the survey process. The Health Care Financing Administration has developed training plans for State Survey agencies so that when any revisions go into effect, we will be ready to implement the changes quickly. Both the proposed changes and the accompanying survey form will be patient outcome-oriented and will serve as better measures of the care actually received by the patients.

In addition to the survey process, the Peer Review Organizations will review medical care given to all Federal beneficiaries in hospitals. They will be responsible for determining the medical necessity and appropriateness and quality of care.

We feel that the proposals developed thus far will ensure quality of care. We appreciate the opportunity to respond to your concerns. The enclosed report addresses the five specific groups of questions you have raised. I want you to know that we are still studying a number of issues regarding the conditions of participation for hospitals, the PRO program, and the Medicare survey process. If you have additional questions, please do not hesitate to let me know. We will be glad to take your concerns into consideration.

A similar letter is being sent to all other members of the committee.

Sincerely yours,

Carolyne K Davis

Carolyne K. Davis, Ph.D.

Enclosure

Answers to the Senate Special Committee on Aging's Questions on Maintaining the Quality of Health Care

1. How will the new State survey evaluate quality of care, including the performance of duties by trained professionals?

We believe that the revised outcome-oriented hospital conditions, particularly the new condition entitled Quality Assurance (QA), will serve as an appropriate mechanism to better guarantee quality patient services for Medicare and Medicaid beneficiaries. The QA condition requires that the hospital have an effective program to identify and resolve problems that affect patient care. A number of the current requirements that specify procedural processes to ensure quality of care have been incorporated into the proposed QA condition. We believe that a focused requirement will simply be a better vehicle through which to address quality of care issues.

The surveyor will determine compliance of the new QA condition by examining whether there is a written plan to evaluate clinical services and medically-related patient care and services, and whether the plan is being effectively implemented. To determine the effectiveness of the hospital's overall QA program, the individual QA activities will be evaluated. The surveyor will determine whether the individual QA activities consider:

- Patient care problems within the individual service;
- Cause of problem(s);
- Corrective action taken; and
- Followup to determine the effectiveness of the action taken.

Surveyors will use several mechanisms in making a determination regarding the effectiveness of the program in meeting the needs of the patient, including medically-related patient services. We will require surveyors to:

- Review a sample of patient records for documentation regarding the nature of post-hospital care arrangements;

- Interview patients who are ready for discharge to determine if medically-related social, psychological, and educational services of the hospital were available to patients needing them; and

- Use specific "indicators" to help measure the facility's program in recognizing important patient care problem areas (i.e., direct observation of clinical performance, interviewing patients and staff, incidents, medication errors, etc.).

A revised Medicare survey form is being developed that will follow the format of the proposed regulations. Therefore, many of the "quality" elements that are now spread throughout the existing survey form will be located under the QA condition. For example, infection control has been moved from the current Medical Staff condition to the QA condition. Health professionals, who are knowledgeable in each area of the conditions, are developing comprehensive interpretive guidelines and survey procedures to complement the proposed regulation. Our objective is to interpret the regulation in greater detail and to provide the surveyor with a better tool to assess patient care and services.

The proposals we are studying, in most cases, do not specify credential and qualification requirements. Rather, they would give responsibility to the hospital for choosing its own staff and delineating staff responsibility. If negative outcomes of patient care are identified during the survey process, the facility will be expected to take appropriate action. One course of action may be to secure more qualified staff.

However, we do feel that any proposed changes should require that the various types of hospital staff must have adequate education, experience, and training in accordance with acceptable standards of practice. In one condition (Compliance with Federal, State, and local laws (Section 482.11)), for example, language has been added to clarify statutory intent that a hospital be required to assure that its personnel are licensed or meet applicable standards required by State or local laws.

2. How often will States be expected to survey each hospital? What steps will be taken to monitor noncompliance with regulations?

By law all hospitals accredited by the Joint Commission on Accreditation of Hospitals (JCAH) (about 5,500) are deemed to meet Medicare requirements, except utilization review. State agency surveys are conducted on all nonaccredited hospitals (about 1,500) participating in the Medicare program. In addition, the State survey agencies survey, on a selective sample basis, JCAH accredited hospitals to determine whether JCAH accreditation continues to assure compliance with Federal requirements. Also, direct Federal monitoring surveys are conducted on a sample of hospitals to check on State and JCAH survey findings. Other surveys are triggered by complaints alleging substandard or improper care, patient abuse, or noncompliance with health or safety requirements. If the hospital is not in compliance with program requirements as a result of any of these survey efforts, it is put under a plan of correction and closely monitored to ensure it meets the plan. However, if there are major deficiencies which jeopardize the health and safety of patients, the hospital is terminated from Medicare.

3. What efforts are planned to train and assist States with the implementation of the new survey system? Are sufficient personnel available to carry out the certification inspections in light of the staff cuts at HHS, as well as in many State agencies?

Anytime there is a major change in regulations we develop and conduct special training for the States. Plans are already underway for such training so that when any changes to the proposed conditions take effect, the Department will be ready for their implementation. The Department pays the States the full personnel cost of performing these surveys. Similarly, current staffing levels within the Department are adequate to preserve and maintain an effective survey and approval program.

4. How will the PROs verify the appropriateness of discharge planning? What mechanisms will be used to determine that social and mental factors were properly evaluated?

Peer Review Organizations (PROs) will not routinely review the appropriateness of a hospital's discharge planning efforts. Since the discharge planning requirement is contained in the conditions of participation, it is the Medicare State Survey Agencies, and not the PROs that are responsible for enforcing it. However, when a patient's stay is unusually lengthy or costly (day or cost outliers), the PRO will conduct a review if the hospital is subject to the prospective payment system. Also, as a part of accomplishing its quality objectives to reduce premature discharge, the PRO will evaluate a hospital's discharge planning efforts where appropriate.

We require each PRO to establish and achieve objectives that address the committee's concerns about the impact of the prospective payment system (PPS) on early discharge and patient complications that may result. PROs will be responsible for achieving specific objectives in five areas which relate to the quality of care provided. Two of these areas deal with reducing instances of premature discharge of patients and underutilization of hospital services which may occur under the PPS. The other three areas address traditional quality of care concerns: reduction of avoidable deaths, complications, and unnecessary surgery or invasive procedures.

The PROs will review a random sample of discharges every quarter from hospitals subject to the prospective payment system to ascertain whether the diagnostic and procedural coding used to assign the Diagnostic Related Groups are consistent with the patient's medical record. PROs will review all outlier cases. In the case of day outliers, denials will be made on a day-by-day basis. In the case of cost outliers, denials will be made on a service-by-service basis as well. Both types of denials will be based on medical necessity and appropriateness of level of care.

Generally, social and mental considerations are not within the PRO jurisdiction. However, in determining the appropriateness of admissions and continued stay, physicians will consider all aspects of the patient's condition, including social and mental factors contributing to the condition and its care. PROs will, of necessity, consider all aspects of the diagnosis and possible complications before making a decision on the case.

5. Will the PROs review the QA programs? Will the new survey system also review this condition, and if so, what standards will be used to determine that QA conditions are being met?

As indicated above (Question #1), review of the QA program will be a responsibility of the survey and approval process. The mechanisms discussed will be used by the surveyor to determine the effectiveness of the program. PROs are, however, required to evaluate quality objectives related to appropriateness of level of care and medical necessity. In addition, the process of survey and peer review will be mutually supportive to assure that quality care is given. In this regard, the PROs and State agency will exchange information with the objective of assisting each other's effort to assure that hospitals maintain acceptable quality of care standards.

JOHN HEINZ, PA., CHAIRMAN

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United States Senate
SPECIAL COMMITTEE ON AGING
WASHINGTON, D.C. 20510

November 29, 1984

Carolyne K. Davis, Administrator
Health Care Financing Administration
330 C Street, S.W.
Washington, D.C. 20201

Dear Dr. Davis:

Thank you for your response to our letter regarding the proposed changes in the Conditions of Participation for Hospitals under Medicare and Medicaid. We appreciate your sharing with us the Department's goals and objectives regarding standard setting for hospitals, and your outline for implementing revisions which are under consideration.

We have reviewed your statements on this matter, both to our Committee and to Representative Henry Waxman, and find that additional information would be helpful to us. We would appreciate your sending us further information and materials as requested below:

1. A copy of the proposed survey.
2. The training plans for the state survey agencies including such items as the proposed schedule, projected staffing needs and budget, and training course outlines.
3. Information regarding the scheduling and projected frequency of the surveying, that is, how often will the new hospital surveys be carried out and when will these begin?
4. Your letter states that you are "still studying a number of issues regarding the conditions of participation for hospitals, the PRO program, and the Medicare survey process." Would you please elaborate on the nature and scope of each of the studies presently under study?

We found your responses to our questions and those asked to you by Congressman Waxman very informative. After studying your responses, we have some additional, more detailed, questions regarding quality of care issues:

1. Will every element of the quality assurance Condition of Participation be of equal import?
2. Will a violation of any one of these elements be sufficient to throw the Condition out-of-compliance?

3. In regard to Peer Review Organizations (PROs) verifying the appropriateness of discharge planning (your response #b to Representative Waxman on October 16, 1984) --

   a Will a minimum "cost or day outlier" (as under the waiver program in New Jersey) be defined in the regulations as a trigger or screen for further review for inappropriate early discharge?

   b How will PROs know who is being readmitted inappropriately?

   c Will PROs evaluate discharge planning of a patient transferred to a nursing home?

   d What are "hospital denial letters?"

   e If the PROs are not responsible for reviewing social services planning (at-home care, Meals on Wheels, mental health, therapy, etc.), who will monitor the transition between hospitals and other non medical post-acute care? How will the quality of this discharge planning be evaluated?

Your letter did not provide any timetable for publishing the proposed changes, and we would appreciate knowing the Department's timetable. We ask that the Secretary not issue any revisions before our Committee members have had an adequate opportunity to review the information requested in this letter. Please be assured that we would consult with you in a timely fashion regarding any possible additional concerns.

Thank you for your cooperation in working with the Committee on this matter. The material we are requesting should help us evaluate the proposed regulations in light of our concerns regarding the quality of care in our nation's hospitals. We share your goal that quality care continues to be provided to some of our nation's most vulnerable citizens, Medicare and Medicaid beneficiaries.

We look forward to your reply.

Sincerely,

John Heinz
JOHN HEINZ
Chairman

John Glenn
JOHN GLENN
Ranking Minority Member

Pete Domenici
PETE DOMENICI
U.S. Senator

Charles H. Percy
CHARLES PERCY
U.S. Senator

Nancy Landon Kassebaum
NANCY KASSEBAUM
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United States Senate
SPECIAL COMMITTEE ON AGING
WASHINGTON, D.C. 20510

January 29, 1985

The Honorable Margaret M. Heckler
Secretary
Department of Health and Human Services
200 Independence Avenue, S.W., Suite 615F
Washington, D.C. 20201

Dear Madame Secretary:

I am writing to request your assistance in obtaining additional records and documents essential to the Committee's ongoing inquiry into utilization of Medicare and Medicaid services and procedures. These materials are reposited in the files of Health Care Financing Administration (HCFA), and are identified and described in the attached schedule.

I would very much appreciate receiving copies of these materials by close of business on February 1, 1985.

Thank you for your continuing cooperation and assistance.

Warm regards,

John Heinz

JOHN HEINZ
Chairman

JH:jss
Enclosure

SCHEDULE OF DOCUMENTS REQUESTED BY THE SPECIAL COMMITTEE ON AGING

1. Any and all versions, including drafts, of the PRO Directive #4, pertaining to Medical Review Implementation.

2. Any and all comments, both solicited and unsolicited, received by HCFA concerning the documents identified above in item #1.

3. Any and all versions, including drafts, of PRO Directive #6, pertaining to Admission Pattern Monitoring.

4. Any and all versions, including drafts, of a PRO Directive that would pertain to certain procedures that have been adopted by several PROs and which may be characterized as attempts by these PROs to implement mandatory second surgical opinion programs.

5. Any and all versions, including drafts, of a policy and/or procedure for witholding and/or suspending payments to, and/or terminating, PROs which fail to meet their contractual obligations to HCFA.

6. Any and all versions, including drafts, of a policy and/or procedure entitled Peer Review Organization Monitoring Protocol and Tracking System ("PROMPTS"), plus internal memoranda, including drafts, which discuss this system and/or the need for such a system.

7. Any and all versions, including drafts, of summary reports generated by HSQB and BPO pertaining to the findings of on-site HCFA visits to PROs, including tables, charts and other data used in preparation of such reports.

8. Any and all versions, including drafts, of memoranda addressed to Carolyne Davis pertaining to the status of PRO implementation, including but not limited to Reports by the PPS Monitoring Committee.

9. Any and all versions, including drafts, of memoranda or reports prepared by HCFA personnel and pertaining to meetings or telephone conversations involving HCFA personnel in Seattle on or about December 12 and 13, 1984.

10. Any and all versions, including drafts, of reports based upon analysis of information contained in PRO Monthly Activity Reports and PRO Quarterly Progress Reports, and generated by the Data Analysis Branch of the Office of Medical Review, HSQB.

11. Any and all versions, including drafts, of memoranda or reports pertaining to PRO Contracts Objectives Modifications.

DEPARTMENT OF HEALTH & HUMAN SERVICES

Health Care Financing Administration

The Administrator
Washington, D.C. 20201

JAN 29 1985

The Honorable John Heinz
Chairman, Special Committee on Aging
United States Senate
Washington, D.C. 20510

Dear Mr. Chairman:

Thank you for your continued interest in the proposed Conditions of Participation for Hospitals under Medicare and Medicaid. We appreciate the opportunity to share issues under consideration and the current status of the proposed regulations.

With respect to your general concern about implementing proposed changes to the Conditions of Participation, we have not established a specific timetable. You are probably aware that we received over 35,000 public comments on the proposed rule published last year. Many addressed major policy issues that the Health Care Financing Administration has been working to resolve. We are still discussing some of the major policy issues within the Department, e.g., credentialing of certain hospital employees, level of experience and training for circulating nurses in the operating room, and requirements on the use of anesthesiologists' assistants. Additionally, revisions must be made to include provisions from the Deficit Reduction Act. I assure you, the Department will not publish the proposed changes as a final rule until we are certain that all issues are resolved satisfactorily.

I have addressed each of your specific questions and requests in detail on the enclosure. I trust this explains each item sufficiently. I appreciate your continuing concern on these issues and the opportunity to work with you to achieve our mutual goal of quality of care for our beneficiaries.

Sincerely yours,

Carolyne K Davis

Carolyne K. Davis, Ph.D.

Enclosure

QUESTIONS/REQUESTS

1. A copy of the proposed survey

It is not possible to provide the survey form at this time. The survey form is directly related to the regulations, which, as stated above, are still being revised. As outstanding issues are resolved and changes made in the regulations, we will be making corresponding changes to the survey form. To release a copy of any draft form at this stage would be misleading.

2. Training plans

Our plans for training are twofold. Initially, we would hold training sessions for Federal regional staff and State survey agency training coordinators. Subsequent training will be conducted by the State survey agencies for their individual surveyors. The State survey agencies will use training materials HCFA will develop to assure consistency in training nationwide. Further, we will provide technical expertise to the State survey agencies for the conduct of these sessions. We project central office costs will be approximately $40,000 for this effort excluding personnel costs. Again, we cannot provide the specifics of the course outline or a schedule until we reach a more definitive set of final rules.

3. Survey scheduling

The frequency of the surveys will be based upon an individual provider's history of compliance with certification requirements. At a minimum, each provider will be surveyed at least every 2 years. Those providers having a poor record of compliance will be surveyed at least once a year. The new survey procedures, using the new survey report form and survey frequencies, will go into effect following publication of final regulations and clearance of the survey report form. Of course, these surveys would be of those approximately 1500 hospitals that are not accredited by the Joint Commission on Accreditation of Hospitals (JCAH). As you know, by law those hospitals accredited by JCAH are deemed to meet Medicare Conditions of Participation and thereby certified.

4. Studies

Our previous letter did not mean to imply that we were conducting formal studies; rather, that we are debating and deliberating policy issues raised in response to the proposed regulations such as those referred to in the second paragraph.

Quality Assurance Questions

1. Will every element of the quality assurance Condition of Participation be of equal import?

   Every element of the quality assurance Condition of Participation is equally important. Each of the 5 elements covers different areas of requirements. All are significant and must be met.

2. Will a violation of any one of these elements be sufficient to throw the Condition out of Compliance?

   A violation of any one of these elements would be sufficient to place the condition out of compliance. However, this does not mean that any element found out of compliance would automatically place the condition out. Our surveyors are trained professionals who make judgements regarding the adequacy of services and therapies. It is their judgment and the exact nature of the problem(s) in the hospital that will determine the result of the survey and appropriate follow-up actions.

3. In regard to Peer Review Organizations (PROs) verifying the appropriateness of discharge planning:

   a. Will a minimum "cost or day outlier" (as under the waiver program in New Jersey) be defined in the regulations as a trigger or screen for further review for inappropriate early discharge?

      The PRO regulations will not define a minimum "cost or day outlier" as a trigger or screen for further review for inappropriate early discharge. The special prospective payment system (PPS) waiver in place in New Jersey permits application of a low "trim point" or trigger for further review of all outlier cases as an exception to PPS.

   b. How will PROs know who is being readmitted inappropriately?

      PROs will identify inappropriate readmissions through medical chart review.

   c. Will PROs evaluate discharge planning of a patient transferred to a nursing home?

      PROs will not routinely evaluate discharge planning of a patient transferred to a nursing home. Such evaluation is within the scope of hospital utilization review (UR) and quality assurance (QA) components.

However, PROs will evaluate discharge plans as an adjunct to regular review activities. This review will involve cases where possible premature discharges are identified. In addition, those cases will be selected for review under the quality objective that is designed to reduce unnecessary hospital readmissions resulting from substandard care provided during the prior admission.

d. What are "hospital denial letters?"

"Hospital denial letters" are notices sent by hospitals to Medicare beneficiaries and their physicians indicating that specified services contemplated and/or received are not covered under Medicare provisions. Such letters must include information regarding reconsideration and/or administrative appeal of denial determinations.

e. If the PROs are not responsible for reviewing social services planning (at-home care, Meals on Wheels, mental health, therapy, etc.), who will monitor the transition between hospitals and other nonmedical post-acute care? How will the quality of this discharge planning be evaluated?

In addition to required review activities, each PRO must pursue objectives to reduce inappropriate or unnecessary procedures and to ensure quality of care. Specific quality objectives are in place to reduce unnecessary hospital readmissions resulting from substandard care provided during the prior admission and to ensure the provision of medical services that, when not performed, have significant potential for causing serious patient complications.

As a part of their responsibility to perform preadmission review and review of premature discharges, PROs will also monitor discharge plans and patient transition. On a day-to-day basis, the quality of discharge planning is the responsibility of hospital UR and QA components.

DEPARTMENT OF HEALTH & HUMAN SERVICES

Office of the Secretary

Washington, D.C. 20201

FEB 12 1985

The Honorable John Heinz
Chairman
Special Committee on Aging
Unites States Senate
Washington, D.C. 20510

Dear Mr. Chairman:

This is an interim reply to your letter of January 29, 1985 to the Secretary requesting eleven categories of documents related to the Department's implementation of the Peer Review Organization (PRO) program.

On February 1, 1985, the American Hospital Association filed a suit against the Department (AHA v. Heckler et. al. #85-0311) which is concerned with implementation of the PRO program. In light of this suit the Health Care Financing Administration has requested an opinion from the General Counsel on the disposition of information about the PRO program. They expect to receive an opinion within a few days and will be responding to your letter at that time.

Sincerely yours,

Cynthia C. Root

Cynthia C. Root
Deputy Assistant Secretary
for Legislation (Health)

DEPARTMENT OF HEALTH & HUMAN SERVICES **Health Care Financing Administration**

The Administrator
Washington, D.C. 20201

March 8, 1985

The Honorable John Heinz
Chairman, Special Committee on Aging
United States Senate
Washington, D.C. 20510

Dear Senator Heinz:

I am writing to convey my concern about the information on the Peer Review Organization (PRO) program that HCFA has recently provided to the staff of the Senate Aging Committee. My concern is based on the enclosed letter from the Acting General Counsel of the Department which deals with a pending law suit against the Department that challenges our implementation of the PRO program. The letter strongly indicates the need for careful control of information on the PRO program while the law suit is in progress. In view of the letter, I believe it is my responsibility to seek your assurance that the information we have provided to the staff of the Senate Aging Committee will be closely guarded against public disclosure, at this time.

I would sincerely appreciate your assistance in this matter.

Sincerely yours,

Carolyne K. Davis, Ph.D.

Enclosure

DEPARTMENT OF HEALTH & HUMAN SERVICES Office of the Secretary

The General Counsel
Washington, D.C. 20201

AAP 2/20

February 20, 1985

MEMORANDUM

TO : Carol A. Kelly
Acting Associate Administrator for Policy, HCFA

FROM : Terry Coleman Terry Coleman
Acting General Counsel

SUBJECT : Release of Certain Documents Requested by the Senate Committee on Aging

You have requested our opinion as to the effect that the release of certain documents requested in a January 29, 1985 letter from the Senate Committee on Aging might have on a lawsuit recently filed against the Secretary by the American Hospital Association (AHA). The AHA has claimed that the Secretary has failed to promulgate regulations allegedly required by law to implement the Utilization and Quality Control Peer Review Organization (PRO) program. Specifically, the AHA alleges that existing transmittals, manual provisions, PRO directives, and individual PRO contracts that govern PRO medical review constitute an unlawful implementation of the PRO statute.

The Senate Committee on Aging, in the request accompanying its letter of January 29, 1985, has asked that HCFA produce various documents pertaining exclusively to implementation of the PRO program. All eleven requests call for "any and all versions, including drafts" of various documents. We believe that the Secretary's position in the current litigation with AHA could be potentially compromised and that burdensome discovery could be requested if these predecisional documents were to fall into the hands of the AHA.

In many cases, these documents represent written drafts by individual staff members that have not been reviewed at any level. In other cases, they represent preliminary analysis of raw, sometimes flawed or imperfect data. At these preliminary stages of development, documents have the potential to be highly misleading, and might be subject to abuse by the AHA in its litigation. For example, preliminary analysis of PRO monthly activity data might reflect errors by a PRO in reporting its data, resulting from its unfamiliarity with new instructions or procedures. Preliminary analysis in the area of modifications to PRO contract objectives thus might inaccurately provide support to AHA's claim that these objectives, and the process which produced them, are somehow flawed.

When used out of context in court, without the benefit of revised, refined, or more complete analysis, such preliminary data could prove damaging to the Secretary's position. Moreover, even if the documents do not ultimately injure the Department's case, the AHA might well use errors or other information contained in the documents to obtain depositions or other discovery. Discovery is ordinarily unavailable in lawsuits challenging agency action, but this obstacle can sometimes be overcome by an assertion of irregularity. Obviously, depositions of agency officials, potentially including senior Department officials, would be extremely burdensome and undesirable.

Other documents requested by the committee represent predecisional versions of the very transmittals and program directives directly named and attacked in AHA's complaint. Experience has demonstrated that such internal, predecisional documents are subject to abuse by plaintiffs when presented out of context, particularly when they may not necessarily reflect the Department's prior or current position.

Finally, certain requested documents reflect the planned implementation of regulations which, as of this date, have not been published. Thus, in addition to prejudice to the lawsuit, release of these documents could potentially compromise the integrity of the relevant rulemaking proceedings.

It is therefore our recommendation that HCFA make every effort to impress upon the oommittee that it would be in the best interests of the Department and the successful implementation of the PRO program for the committee to withdraw its request until the conclusion of the current litigation with AHA. In the alternative, if this information is released to the committee, HCFA should insist on assurances from the committee that these documents will be held in strict confidence, and that steps will be taken to insure that they do not become available to the public, and thus to the AHA.

JOHN HEINZ, PA., CHAIRMAN

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United States Senate
SPECIAL COMMITTEE ON AGING
WASHINGTON, D.C. 20510

March 28, 1985

The Honorable Margaret M. Heckler
Secretary of Health and Human Services
200 Independence Avenue, S.W.
Washington, D.C. 20201

Dear Secretary Heckler:

I am writing to request your assistance in obtaining clarification on a letter dated March 8, 1985, addressed to me from Carolyne K. Davis, Ph.D., Adminstrator for the Health Care Financing Administration (HCFA). Please find enclosed a copy of the letter and an attached memorandum to Dr. Davis from Terry Coleman, Acting General Counsel for the Department.

In her letter, Dr. Davis states that, in light of a pending lawsuit, there is "the need for careful control" by this Committee of documents received from HCFA regarding the Peer Review Organizations (PROs). Her letter follows similar requests concerning these same documents that were relayed by Hans Kuttner of your staff to James Michie of the Committee staff on February 27, 1985, and March 7, 1985. Mr. Michie asked Mr. Kuttner on each of those occasions to request that HCFA identify the documents and/or portions of documents considered to be of a sensitive nature.

This Committee has no wish to interfere with due process in the pending lawsuit against the Department. It is essential, however, for Dr. Davis to identify with specificity those documents and/or portions of documents regarding the PROs that may warrant careful control so that this Committee may give adequate and informed consideration to her request.

Thank you for your assistance and cooperation in this matter.

Sincerely,

JOHN HEINZ
Chairman

JH:jmm

DEPARTMENT OF HEALTH & HUMAN SERVICES Office of the Secretary

Washington, D.C 20201

May 28, 1985

The Honorable John Heinz
Chairman, Special Committee on Aging
United States Senate
Washington, D.C. 20510

Dear Senator Heinz:

This is in reply to your recent letter to the Secretary requesting more specific information on the protection of documents related to the Peer Review Organization (PRO) program. As you know, we are concerned about the use of this information in light of the pending lawsuit against the Department.

In an effort to clarify our previous communications with you, the Department has identified two categories of sensitive information that warrant special consideration. The first category encompasses documents that deal with the policies and procedures to be followed by the PROs in the implementation of their review programs. Departmental officials believe this information is considered sensitive because the lawsuit concerns many aspects of the implementation of the PRO program that are addressed in these documents. This category includes such documents as draft regulations, drafts of internal policy papers, issue papers and staff memoranda on PRO review methods or procedures; draft program instructions and directives; minutes of meetings or conversations on PRO review policies or procedures, etc. Many documents previously sent to the Committee fall into this category. For example, it would encompass the material requested by items #1 -6 and 11 of your letter to the Secretary dated January 29, 1985 (enclosed).

The second category encompasses documents that are concerned with the evaluation of PROs in the performance of their responsibilities. This would include drafts of internal documents that evaluate the performance of individual PROs or the program in general; medical review activity reports submitted by the PROs; documents of an evaluative nature that are exchanged between Health Care Financing Administration (HCFA) program staff and the HCFA Contracts Office, etc. This information is considered sensitive because the lawsuit also concerns the processes to be used to evaluate PROs. Material of this nature is exemplified by items 8 and 10 of your letter of January 29.

The Aging Committee Staff have obtained many other documents that are not specifically identified in this letter. Should there be any questions about these materials, we will arrange for HCFA staff to provide further clarification to the Committee staff.

Sincerely yours,

DeNardis

Lawrence J. DeNardis
Acting Assistant Secretary
for Legislation

Enclosure

SCHEDULE OF DOCUMENTS REQUESTED BY THE SPECIAL COMMITTEE ON AGING

1. Any and all versions, including drafts, of the PRO Directive #4, pertaining to Medical Review Implementation.

2. Any and all comments, both solicited and unsolicited, received by HCFA concerning the documents identified above in item #1.

3. Any and all versions, including drafts, of PRO Directive #6, pertaining to Admission Pattern Monitoring.

4. Any and all versions, including drafts, of a PRO Directive that would pertain to certain procedures that have been adopted by several PROs and which may be characterized as attempts by these PROs to implement mandatory second surgical opinion programs.

5. Any and all versions, including drafts, of a policy and/or procedure for witholding and/or suspending payments to, and/or terminating, PROs which fail to meet their contractual obligations to HCFA.

6. Any and all versions, including drafts, of a policy and/or procedure entitled Peer Review Organization Monitoring Protocol and Tracking System ("PROMPTS"), plus internal memoranda, including drafts, which discuss this system and/or the need for such a system.

7. Any and all versions, including drafts, of summary reports generated by HSQB and BPO pertaining to the findings of on-site HCFA visits to PROs, including tables, charts and other data used in preparation of such reports.

8. Any and all versions, including drafts, of memoranda addressed to Carolyne Davis pertaining to the status of PRO implementation, including but not limited to Reports by the PPS Monitoring Committee.

9. Any and all versions, including drafts, of memoranda or reports prepared by HCFA personnel and pertaining to meetings or telephone conversations involving HCFA personnel in Seattle on or about December 12 and 13, 1984.

10. Any and all versions, including drafts, of reports based upon analysis of information contained in PRO Monthly Activity Reports and PRO Quarterly Progress Reports, and generated by the Data Analysis Branch of the Office of Medical Review, HSQB.

11. Any and all versions, including drafts, of memoranda or reports pertaining to PRO Contracts Objectives Modifications.

THE SECRETARY OF HEALTH AND HUMAN SERVICES
WASHINGTON, D.C. 20201

JUN 19 1985

The Honorable John Heinz
Chairman, Special Committee on Aging
United States Senate
Washington, D.C. 20510

Dear Mr. Chairman:

This is in response to your letter regarding the General Accounting Office (GAO) preliminary report on the impact of the prospective payment system (PPS) on post-hospital care. Please pardon the delay in my response.

It should be noted that GAO's purpose in developing the report was to identify the issues related to post-hospital care of Medicare patients, rather than to draw conclusions on this subject. The GAO report calls upon the Department to conduct research on the issues it raises concerning the impact of PPS on the quality of post-hospital care. The Department is actively engaged in such research. The Office of the Assistant Secretary for Planning and Evaluation (ASPE) has a contract with the Urban Institute to further refine the research issues in this area and to identify feasible studies. The Health Care Financing Administration (HCFA), ASPE, and the Office of Human Development Services (OHDS) plan to fund those studies identified as the highest priority. In addition, HCFA's Office of Research and Demonstrations is considering research proposals in this area submitted under its current grant solicitation. After technical review, high quality projects will be funded.

Let me assure you that this Department is committed to assuring that our Medicare beneficiaries receive high quality care. This is true regardless of the method of reimbursement. We designed our medical review system to assure that quality was maintained under PPS. For example, readmissions shortly after a prior hospital stay could indicate poor quality of care. Therefore, with implementation of PPS, all medical review entities (Professional Standards Review Organizations and fiscal intermediaries) reviewed admissions to assure that they were medically necessary and appropriate. They also reviewed all readmissions within 7 days in order to identify cases where patients were prematurely discharged. Both of these review activities continue under the utilization and quality control peer review organization (PRO) program.

I have been assured that HCFA has not identified any pattern of poor quality care under PPS to date. However, HCFA has received some anecdotal information about isolated instances of poor quality (e.g., premature discharge and inappropriate transfers from acute settings to lower levels of care). In these cases, HCFA investigates thoroughly through the PROs and, where poor quality is identified, the PROs take corrective action against the facility or physician found to be at fault. Corrective actions could range from intensive review to exclusion from the Medicare program.

In your recent letter, you also asked what recourse patients have if they feel they have been discharged prematurely. At the outset, I would note that,in an effort to address misconceptions surrounding PPS, the next issue of HCFA's Medicare/Medicaid Notes, which is distributed to beneficiary consumer groups across the country, is being devoted to clarifying PPS policy issues. HCFA is pursuing additional initiatives involving the media to better inform the public at large on PPS.

While we are concerned that Medicare beneficiaries receive appropriate medical care, it is important to note that the decision to admit or discharge a patient is made by the attending physician, not the PRO. Hospitals and physicians have been notified that Medicare's average length of stay for a diagnostic related group is indeed an average, not a limit. Therefore, physicians should not discharge patients who are not ready to leave the acute care setting. Patients or their families who believe the hospital or the physician is discharging the patient prematurely should discuss the matter with the patient's physician because he or she ultimately makes the discharge decision.

In cases in which a hospital recommends discharging a patient and the attending physician disagrees, the PRO physician advisor is required to review the case to determine if Medicare coverage is appropriate. The review focuses on whether the services are medically necessary, delivered in the most appropriate setting, and meet medically recognized standards of care. If the PRO decides that discharge is appropriate and the attending physician elects to keep the patient in the hospital, the patient may decide to exercise his or her Medicare coverage reconsideration and appeal rights. Medicare regulations require that the hospital issue written notices advising beneficiaries of a denial of Medicare benefits and that these notices contain specific information for the protection of beneficiaries as well as the hospitals. In May, 1985, HCFA issued an instruction requiring PROs to monitor the specific information contained in these hospital notices to ensure that they comply with these regulations.

When Medicare beneficiaries are admitted to a hospital, they are notified that their care is subject to PRO review and advised of the procedures they should follow if they are dissatisfied with the PRO's decision. Because the patient is hospitalized, the PRO must complete its reconsideration effort within a very limited time period. Also, if a patient receives a Medicare coverage denial from the PRO, the notice specifies the locations and procedures for requesting a reconsideration. Therefore, we believe that patients are fully informed of the presence of a medical review agent who is responsible for assuring that they receive necessary and appropriate medical care.

In addition to admission review, each PRO has committed itself to achieving objectives which address major problems of patient care quality identified in the PRO's area, such as inappropriate admissions, patient transfers, unnecessary surgery, and medical complications. If PROs identify problems with quality of care, they must consider imposing corrective action as explained above.

To supplement the monitoring activities performed by PROs, we are always ready to answer inquiries or complaints from beneficiaries. HCFA investigates such cases either through the HCFA regional office or by contacting the PRO directly.

Regarding the proposed elimination of the waiver of liability for certain Medicare providers, the proposed rule would eliminate only the criteria for determining whether a provider of Part A services is eligible for a presumption that it did not know or could not reasonably have been expected to know that the services it furnished would be denied by Medicare (as being not medically reasonable and necessary or involving custodial care). HCFA would still continue to make program payment under the waiver of liability provision based on a case-by-case analysis where it is determined that neither the provider nor the beneficiary knew or could reasonably have been expected to know that the services were not covered. Also, a provider would retain its right to appeal any case where it is held liable and is not paid under the waiver of liability provision. A work group has been formed within HCFA to evaluate carefully the numerous comments received concerning this proposed regulation. One of the issues that will come under intensive scrutiny by the work group is the concern you raise regarding potential disincentives to providing services to Medicare patients.

With respect to your concerns regarding the availability of post-hospital care, we believe that home health agencies and skilled nursing facilities (SNFs) are able to handle the slight increase in volume shown by our PPS statistics. It should be noted that there has been a tremendous increase in the number of Medicare-certified home health agencies from 2,858 in 1980 to 5,320 in December 1984, an 86 percent increase. Moreover, following discussions with industry representatives and congressional staff, HCFA issued additional guidelines in April 1984. These guidelines specified that patients' need for care should be the primary factor in determining whether daily home care would be provided and noted that the 2-3 week guideline governing exception to the intermittent care requirement is not an absolute limit. We will continue to evaluate the effect of our current policies.

Let me emphasize again that the Department shares the desire of Congress to secure accurate and timely information that will identify the scope and degree of any problems in implementing the prospective payment system. We appreciate your comments on this important issue.

Sincerely,

Margaret M. Heckler

Margaret M. Heckler
Secretary

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United States Senate
SPECIAL COMMITTEE ON AGING
WASHINGTON, DC 20510

July 24, 1985

The Honorable Margaret M. Heckler
Secretary of Health and Human Services
Washington, D.C. 20201

Dear Madam Secretary:

As Chairman of the Senate Special Committee on Aging, I am writing to share with you my deep concern over growing indications of serious and sometimes fatal flaws in monitoring quality of care under the Medicare Prospective Payment System (PPS).

Written into the 1983 amendments creating the PPS are explicit safeguard measures to ensure that reductions in cost of care do not translate into compromises in quality of care. Congress intended the peer review organizations (PROs) to be the program's watchdogs, reviewing the "quality of care, the necessity and reasonableness of care, and the appropriateness of the setting" in which care is provided. Madam Secretary, I recognize the magnitude of the quality review process. But I know you share my commitment to make the process work, for on its success rides the wellbeing of millions of older Americans.

I have expressed my concerns on the issue of quality of care under the PPS through correspondence with you on several occassions over the past 18 months. Most recently (June 19), you responded to my serious concerns raised by a General Accounting Office report to me on the impact of the PPS. You wrote you had "been assured" that the PROs were taking the proper "corrective action" in the "isolated instances of poor quality care" which HCFA had received through "anecdotal information."

On April 19, Administrator Carolyne Davis of the Health Care Financing Administration testified before the Senate Finance Committee that HCFA doesn't "see any evidence of major problems with premature discharge or inappropriate transfer--but we are finding individual cases." According to Dr. Davis, "fewer than 200 cases had been referred to the regional offices so far." She reassured the Committee that HCFA had "met the challenge of creating a strong, effective quality and utilization review program."

Given HCFA's strong assertions to you and the public that Medicare beneficiaries are "safe and sound" under the PPS, I frankly am appalled at the paper trail of evidence to the contrary uncovered this week by the Aging Committee staff.

Specifically, in an October 1984 memorandum to HCFA Administrator Davis, the Inspector General of DHHS reported a "serious problem" in the implementation of the PPS. "Evidence is mounting to suggest abuse of the PPS is occurring through premature discharge and inappropriate transfer of patients," the Inspector General wrote.

He cited 1130 cases identified as of July 1984, with only about 50 percent of the PROs reporting. Far from "anecdotal information about isolated instances," the Inspector General concluded that the "impact of this type of abuse on quality is so significant that its potential visibility could jeopardize the integrity of the medical review process and the payment system."

I regret to inform you that the problem of abuse has grown far worse in the last year. Discharges and transfers red-flagged by the PROs as inappropriate had risen to 3700 by March of this year. I trust you will understand my utter dismay and outrage over HCFA's failure to act on such critical--or fatal--patient outcomes as: (1) "patient apparently succumbed to a treatable condition on readmission"; (2) "patient ... transferred to rehab unit [and] expired in rehab unit"; and (3) "anemia was not treated on first admission; patient was readmitted with profound anemia."

Yet we have no record that the corrective or punitive powers authorized by Congress have been exercised. To the contrary, the memoranda I have reviewed suggest the PROs are paralyzed without instructions from HCFA clarifying their corrective responsibilities.

In the October correspondence mentioned above, the Inspector General contended that existing instructions did not require "corrective action," and recommended that an immediate clarification be made to "avoid possible adverse patient outcomes." Three months later, in January of this year, Administrator Davis responded, agreeing that "HCFA's instructions should be revised, as soon as possible."

Madam Secretary, almost ten months have passed since the IG's report, yet the clarifying instructions to the PROs have not been issued. I am at a complete loss to understand this delay, especially since the IG's report provided examples of deaths of patients as a result of inappropriate transfers and hospital admissions.

I ask your Department's full cooperation in correcting flaws in the PPS which so seriously threaten the lives of millions of older citizens. We must not rest on reassurances that so belie the apparent reality of increasing abuses.

First, we need an immediate issuance of the PRO clarifying instructions from HCFA, so that no further delays occur in corrective actions. Second, I need your help in securing speedy answers to the attached questions. And third, I ask your assistance for Aging Committee staff while they undertake a full investigation of the PPS/PROs effect on quality of care. In this regard, it is essential that my staff be provided complete and unrestricted access to all DHHS and PRO contractor personnel, as well as to all data, reports, memoranda, correspondence and other documentation, including draft and final versions.

Madam Secretary, it is past time we put the PROs on track once and for all, fully armed with the authority Congress mandated, and thus able to guarantee the quality of care we have pledged to preserve.

Sincerely,

John Heinz

JOHN HEINZ
Chairman

JH/ick
Enclosures

SCHEDULE OF QUESTIONS REGARDING PPS IMPACT ON QUALITY OF CARE

1. In her January 18, 1985, response to the DHHS OIG's October 1984 report on "Inappropriate Readmission and Transfer Practices under the Prospective Payment System," Dr. Carolyne Davis, Administrator of HCFA, stated that "HCFA's instructions [to the PROs] should be revised, as soon as possible, to require PROs to make denials or to require corrective actions, such as sanctions, in readmission and transfer cases involving medically inappropriate practices."
Regarding this response, please provide answers to the following questions along with all supporting documentation: (a) On what date and to whom was the task of revising the instructions assigned; (b) What was the level of resources dedicated to this task; (c) Specifically when did the effort toward revising the instructions begin; (d) When and by whom was the first draft of the instructions completed, and on what date and to whom was the first draft forwarded for comment, editing, or for any other purpose (please identify); (e) On what date and by whom was each additional draft completed, and on what date and to whom was each of these additional drafts forwarded for comment, editing, or for any other purpose (please identify); (f) When will the instructions be finalized, approved and forwarded to the PROs; (g) please provide a copy of each of the drafts along with written comments, annotation, and/or editing pertaining to each of the drafts.

2. Dr. Davis' January 18, 1985, response to the IG report stated: "we sent a draft memorandum to the regional offices on October 26, 1984, for comments and conducted a conference call on November 14 with the regions. Based on their input and further analysis we are developing program guidance which outlines specific situations and specific interventions that must be taken where inappropriate readmissions or transfers are identified." Please provide a copy of the "draft memorandum", a copy of the "comments" from each of the regional offices, and any and all memoranda and minutes generated by the regional offices and by officials and personnel within HCFA offices in Baltimore, Md., and in Washington, D.C., and pertaining to the "conference call" on November 14, 1984.
Please answer the following questions and provide all supporting documentation: (a) To whom, and on what date, was the task of "developing program guidance which outlines specific situations and specific interventions" assigned (please provide a copy of all memoranda and correspondence generated within DHHS and HCFA and pertaining to development of the "program guidance"); (b) what is the number of inappropriate readmissions and the number of inappropriate transfers identified by each of the PROs (please specify) for each of the months from July 1984 to the present; (c) what corrective action or intervention, if any, has been taken for each of these inappropriate readmissions and transfers identified by each of the PROs, and when and by whom was the action or intervention taken?

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3. Dr. Davis' January 18, 1985, response to the IG's October 1984 report states: "I have instructed my staff to consult with appropriate members of your staff in developing policy papers in this area." Please provide answers to the following questions along with all supporting documentation: (a) To whom, and on what date did Dr. Davis issue instructions for consulting with OIG staff; (b) With whom on the OIG staff, and on what date(s) did Dr. Davis' staff (please identify) consult; (c) please provide a copy of all memoranda and other records generated by HCFA and DHHS officials and personnel and pertaining to meetings, conferences and telephone conversations with members of the OIG staff on development of policy papers; (d) please provide a copy of all such policy papers, draft and final versions, that have been generated to date within HCFA and DHHS.

4. Dr. Davis' January 18, 1985, response to the IG's October 1984 report states: "Additionally, in the next year, we expect to publish regulations changing the method by which transfer cases between PPS hospitals are paid."
Please provide answers to the following questions along with all supporting documentation: (a) To whom, and on what date, was the task for drafting these regulations assigned; (b) What was the level of resources dedicated to this task; (c) Specifically when did the drafting of these regulations begin; (d) When and by whom was the first draft of these regulations completed, and on what date and to whom was the first draft forwarded for comment, editing, or for any other purpose (please identify); (e) On what date and by whom was each additional draft completed, and on what date and to whom was each of these additional drafts forwarded for comment, editing, or for any other purpose (please identify); (f) what is the current status of these regulations; (g) when will these regulations be finalized for publication; (h) please provide a copy of each of the drafts of the regulations along with written comments, annotation, and/or editing pertaining to each of the drafts.

5. Why did it take HCFA more than 12 weeks to respond to the IG's October 1984 report on "Inappropriate Readmission and Transfer Practices under the Prospective Payment System" (please provide all supporting documentation)?

6. Why has HCFA not yet issued to the PROs the urgently needed revisions of the instructions regarding inappropriate readmissions and transfers (please provide supporting documentation)?

7. Was HCFA required to obtain legal opinion(s) and clearance(s) regarding these instructions to the PROs? If so, on what date(s) and to whom did HCFA submit these instructions for legal opinion(s) and clearance(s), and please provide all supporting documentation pertaining to these actions. Please provide a copy of all memoranda, correspondence, notes and any other documentation generated within HCFA and by whomever provided legal opinion(s) and clearance(s) concerning these instructions to the PROs.

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8. HHS presently requires PROs to investigate readmissions to a hospital if the patient is readmitted within 7 days of being discharged from that hospital. Has HHS evaluated Medicare data to determine whether a two-week or one month threshhold for readmissions might identify more cases of premature discharge and poor care? Please provide all data and documentation used in any such evaluation, together with the name of the person(s) assigned to this task. If HHS has not evaluated redefining the threshhold for readmissions to be examined by the PROs, please explain why it has not, and provide any supportive documentation related to the decision to use a 7 day threshhold.

9. Of the approximately 3,700 patients judged by the PROs to have received poor or inappropriate care and subsequently referred to HCFA Regional Offices, has HHS conducted any analysis of these cases to determine what (if any) patterns are discernable? Specifically, has HCFA analyzed this data to determine:

(a) which DRGs are most often implicated in these cases;
(b) the proportion of beneficiaries affected by these practices who are Medicaid eligible, compared to the proportion of Medicaid eligibles in the Medicare population;
(c) the hospital characteristics (if any) that typify the institutions engaging in these practices (such as bedsize, ownership status, chain affiliation, etc.);
If no such analysis has been undertaken, please assign an appropriate staff person to work with the Committee on an evaluation of potential patterns involving these abuses.

10. Have there been any attempts to calculate, or estimate, the number of patient deaths that may be attributable to inappropriate readmission and transfer cases? If not, please explain why this has not been attempted. If so, at least in the case of those PROs that have recorded such events, please provide the totals from each of those PROs for each month from July 1984 to the present (please provide supporting documentation). Please provide documentation on what action, if any, has been taken by the PRO and/or HCFA regional office involved, or by HCFA HQ, regarding each of these cases.

11. Have there been any attempts to calculate, or estimate, the number of serious and adverse patient outcomes that may be attributable to inappropriate readmission and transfer cases? If not, explain why this has not been attempted? If so, at least in the case of those PROs that have recorded such events, please provide the totals from each of those PROs for each monthy from July 1984 to the present (please provide supporting documentation). Please provide documentation on what action, if any, has been taken by the PRO and/or HCFA regional office involved, or by HCFA Central Office regarding each of these cases.

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12. According to HCFA's Office of Medical Review, HSQB, a large number of PROs are reporting very seldom, or not at all, adverse patient outcomes resulting from inappropriate readmissions and transfers. Why is this so? Please identify those PROs that are seldom reporting such adverse patient outcomes, and provide supporting documentation. Please identify those PROs that are not reporting any such adverse patient outcomes, and provide supporting documentation.

13. What has been the impact of PRO reviews to date under Quality Objective I, aimed at reducing unnecessary hospital readmissions within 7 days resulting from substandard care or premature discharge during prior admission(s)? Please provide documentation of this impact, broken down by individual PRO.

14. Has HHS compared "Baseline" data on the incidence of poor care and premature discharge in 1983, provided by each PRO in its quarterly Progress Report for Quality Objective I, to current data (being reported by the PROs under this Objective and their monthly reported Regional Office referrals)? If so, please provide all supporting documentation. If not, please assign an appropriate HCFA staff person to assist the Committee in an inquiry of this type.

15. In a letter dated November 27, 1984 to the Director of the Human Resources Division of the U.S. General Accounting Office, Mary Kenesson of HCFA's Bureau of Quality Control stated that "BQC is presently involved in the first phase of a study to measure the impact of hospital PPS on home health agencies (HHAs) and skilled nursing facilities (SNFs)."
Please provide copies of any and all documentation, including draft and final memoranda and other records pertaining to meetings, conferences, telephone coversations, and any preliminary or final data and findings resulting from this study.
16. Ms. Kenesson's letter also refers to another study involving some 9,000 Medicare beneficiaries' claims records, called "Beneficiary Profiling System (BPS)". Please provide copies of any and all documentation, including draft and final memoranda and other records pertaining to meetings, conferences, telephone conversations, and any preliminary or final data and findings resulting from this study.

17. In your letter of June 19, 1985, you indicate "the Department is actively engaged" in research on "the impact of PPS on the quality of post-hospital care". For each each study cited below, please provide copies of any and all documentation, including draft and final memoranda and other records pertaining to meetings, conferences, telephone conversations and any data and preliminary findings resulting from the study.
(a) What is the status of the ASPE/Urban Institute research project (please provide supporting documentation detailed above)?;
(b) What is the status of each research proposal submitted to date to HCFA's Office of Research and Demonstrations (ORD) in

response to its current grant solicitation (please provide supporting documentation for each such proposal)?

18. The June 19th letter also identifies certain other data and actions involving HHS' response to the problem of poor care and premature discharge. For each of the following questions, please provide all supporting documentation.
(a) HCFA has assured you that they have "not identified any pattern of poor quality care under PPS to date". Has HCFA informed you of the contents and importance of the OIG report of October 1984?
(b) The June 19th letter then states that "HCFA has received some anecdotal information about isolated instances of poor quality (e.g. premature discharge and inappropriate transfers from acute settings to lower levels of care). In these cases, HCFA investigates thoroughly through the PROs, and, where poor quality is identified, the PROs take corrective action against the facility or physician found to be at fault."
Please provide, for each of the anecdotes received by HCFA, copies of the anecdotal information received, together with copies of all memoranda, records of telephone conversations and meetings, investigative findings and corrective actions required by the PROs as a result of these investigations.
(c) This letter also refers to actions taken by the Department to ensure that beneficiaries are well informed regarding their benefits under PPS. What specific actions has the Department undertaken to notify beneficiaries of their rights to notice and opportunities for reconsideration and appeal of a termination of hospital, SNF and HHA Part A benefits (please provide supporting documentation)?;
(d) How many reconsiderations, and how many appeals, have Medicare beneficiaries filed under each of these Part A benefits since January 1, 1982? Please provide supporting documentation for each of these Part A benefits, broken down by individual Fiscal Intermediaries in each State, by month or by quarter, since the beginning of 1982.

19. The Committee's 1984 investigation of Medicaid discrimination by nursing homes revealed that Medicaid eligible Medicare patients were more likely to be subjected to pressures for early discharge -- and least likely to be accepted by nursing homes. Has the Department notified the State survey and certification agencies of the illegality of certain forms of Medicaid discrimination that have reportedly been exacerbated by PPS, as agreed by Under Secretary Charles Baker in October 1984?

20. In addition to the PROs, the Department funds another network of "watchdogs" to monitor and report on quality and access to health care: the long term care Ombudsman programs. What actions has the Department taken to train and utilize these 600+ programs to improve the government's knowledge of and response to problems in long term care settings resulting from PPS (please provide all supporting documentation)?

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21. When a PRO denies payment to a hospital because of an inappropriate discharge or readmission, or denies payment for SNF care because of too short of a prior hospital stay, what costs does the beneficiary incur?

JH COMMENTS AT QUALITY OF CARE PRESS CONFERENCE
THURSDAY, 25 JULY 1985 11:00 AM
Dirksen 628

Good morning. Two years ago, Congress responded to skyrocketing health care costs and the imminent bankruptcy of Medicare with changes in the reimbursement method for hospitals under Part A of the program. Under the Prospective Payment System, hospitals are reimbursed for care on a predetermined, specific rate for a specific diagnosis rather than billing the government for a "reasonable cost."

From its inception, I and others have been concerned that the so-called PPS made older Americans on Medicare vulnerable to skimping on quality care. Specifically, I have expressed concern that hospitals would attempt to hedge the system through premature discharges or inappropriate transfers of patients.

Written into the 1983 amendments creating the PPS are explicit safeguard measures to ensure that reductions in cost of care do not translate into compromises in quality of care. Congress intended the peer review organizations --the PROs--to be the program's watchdogs, reviewing the quality and reasonableness of care and reporting any abuses to the Health Care Financing Administration (HCFA).

Now I have been repeatedly reassured by the Administration--as recently as last month--that the PRO's are functioning as Congress intended. In a letter from HHS Secretary Heckler on June 19, she said the PROs were taking the "proper corrective action" in the "isolated instances" of poor quality care which HCFA had received through "anecdotal information."

Secretary Heckler's information came from HCFA. Administrator Carolyne Davis offered similar assurances to the Congress at an April hearing of the Senate Finance Committee. Dr. Davis testified that HCFA didn't see "any evidence of major problems with premature discharge or inappropriate transfers." According to Dr. Davis, fewer than 200 cases had been referred to the regional offices.

Given the Administration's consistently strong assertions that Medicare beneficiaries are safe and sound under the PPS, I frankly am appalled at the paper trail of evidence to the contrary uncovered this week by the Senate Special Committee on Aging staff.

The good news is yes, some PROs are striving to review and report as Congress intended. The bad news is that few if any corrective actions have been taken in the face of revolving door discharges and patient shuffling. The bitter news is that HCFA has buried the truth on the magnitude of the problem.

And it is a bitter pill indeed. Rather than the "isolated instances" cited by the Administration, as of March of this year, there were 3700 cases of discharges and transfers red-flagged by the PROs. And this was with only about 50 percent of the PROs reporting! The cases I have reviewed are blatant examples of calculated gaming by hospitals and doctors, where the stakes are the lives of thousands of sick, older Americans.

Take the case of Mr. A, a 64-year-old who was admitted to the hospital with severe back pain, muscle spasms and impaired movements resulting from a fall. After 5 days he was discharged, with a physician's discharge statement which read, "the patient should have been kept in the hospital longer for treatment, however because of DRGs, he was dismissed."

Mr. Y, 70 years old, had a stroke, heart failure, diabetes, and impending gangrene in his right leg. He had been placed in a hospital-based rehabilitation center for 20 days and transferred to an intensive care unit when his temperature reached 101 and his leg was cold to the touch. They only kept him there one day, then transferred him back to the rehab unit, in his bed, with a temperature of 102, and an intravenous line to his heart. He died the next morning.

You'll find additional cases in your information packets.

Now what is the problem here? The Inspector General of HHS sent a letter to HCFA in October 1984, alerting the Administrator of mounting evidence of abuse of the PPS through premature discharge and inappropriate transfer of patients. At that point, he reported 1130 cases identified by the PROs. Yet we have no record that the corrective and punitive powers authorized by Congress have been exercised. To the contrary, the memoranda I have reviewed this week suggest the PROs are paralyzed without instructions from HCFA to clarify their corrective responsibilities.

Again, in correspondence last October the Inspector General told HCFA that existing HCFA instructions to the PROs did not require "corrective action." He recommended that an immediate clarification be made. Three months later, in January of this year, HCFA wrote back, agreeing that instructions should be revised as soon as possible.

A total of ten months have passed, yet no clarifying instructions have been issued. I am at a complete loss to understand this delay, especially since HCFA has been made aware of deaths resulting from inappropriate transfers or discharges.

HCFA, in failing to clairfy the enforcement powers of the watchdog PROs, lets them bark, but muzzles their bite.

It is time to set the record straight. The Congress and the American public deserve the truth, not false reassurances. Each day that passes without the full use of corrective powers in the hands of the PROs we risk lives and encourage suffering.

Today, in response to the large and growing number of patients being wrongly and dangerously put at risk, I am sending a letter to Secretary of HHS Heckler, asking her full cooperation in correcting the problems I've outlined. We need immediate instructions to the PRO's to crack down on those hospitals prematurely discharging patients. We need the HCFA to give us timely, accurate information on the problem. And I am asking that the Secretary give us the full cooperation of her office in assisting this Committee in an investigation I am ordering today into the true status of the PRO's and the quality of care they are supposed to monitor.

Equally important, I wanted the Secretary to understand that Congress will not tolerate the kind of manipulative, misleading distortions of reality that we have been fed on this issue. It is past time we put the PROs on track once and for all, fully armed with the authority Congress mandated, and thus able to guarantee the quality of care we have pledged to preserve. Our failure to do so will only undermine the Prospective Payment system and jeopardize the health and welfare of this nation's 30 million Medicare beneficiaries.

Case Summary -- Patient 1

(TRANSFERRED PT. TO REHAB DESPITE POOR CONDITION OF PT.)

This 70 year old man had had a stroke, heart failure, diabetes, and impending gangrene in his right leg. He had been placed in a hospital based rehabilitation unit for 20 days from 4/6 to 4/26. On the 26th, he was transferred to the intensive care unit because his leg was cold, he had a temperature of 101, and he was lethargic. On the 27th, he was transferred directly from the intensive care unit -- in his bed, with a temperature of 102 and an intravenous line to his heart -- to the rehab unit. At 8:30 the next morning, he died.

Case Summary -- Patient 2

(PREMATURE DISCHARGE)

This 64 year old man had suffered a fall and, as a result, needed treatment for severe back pain, muscle spasms, and extremely impaired ability to bend forward or backward. He also had a collapsed lung. He was admitted to the hospital on 5/9, given physical therapy, and discharged on 5/14. The physician's discharge statement reads, "It is felt the patient should have been kept in the hospital longer for treatment, however because of DRG's, he was dismissed. The patient was explained this, that he was being dismissed before he should because there was nothing else that could be done."

Case Summary -- Patient 3

(QUESTIONABLE/PREMATURE DISCHARGE)

This 88 year old male was admitted to the hospital on 4/15 with paralysis on his right side, severe pain in his right leg, extreme weakness, shortness of breath, and inability to walk and swallow. He required intravenous solutions throughout his hospital stay. On 4/28, he was discharged, according to the doctor's discharge statement, "at the request at the hospital since his Medicare would no longer cover payment for treatment."

Case Summary -- Patient 4

(POOR CARE / PREMATURE DISCHG.)

This 71 year old man was discharged too early from the hospital after having had surgery to remove a bladder tumor. He was discharged three days after surgery, without having a post-operative bowel movement. He returned to the emergency room that afternoon, with abdominal pain and constipation. He was readmitted at 4:10 p.m. for observation and further treatment.

Medicare's claims reviewer noted, "...this definitely looks like dischg'd too early....What can we do?"

Case Summary -- Patient 5

(INADEQUATE DISCHARGE PLAN)

This 70 year old man was admitted to the hospital on 4/5, suffering from acute back pain due to lumbago. He was treated for five days and released on 4/10 in the morning, according to the physician's discharge statement "even though the low back pain had not resolved completely."

Because the patient was unable to care for himself at home and his wife was unable to provide nursing care, he was readmitted to the hospital just a few hours after he was discharged.

Case Summary -- Patient 6

(INAPPROPRIATE TRANSFERS TO REHAB.)

This 86 year old man was originally admitted to the hospital with chronic heart conditions, unstable angina, renal failure, and general debility. Despite his frail and chronic condition, the physician had him transferred from the PPS hospital and admitted to the rehabilition section of the same hospital. The physician's discharge statement reads, "The patient was evaluated and was found to be extremely unstable. Even so, a gentle rehabilitation program was started but it was rapidly noted that this was going to be an impossible situation and the patient started showing more evidence of cardiac decompensation."

The patient was transferred back to the hospital in early February. The patient was transferred back to the Rehab facility and then back again to the hospital, where he died in early March.

Case Summary -- Patient 7

(INADEQUATE DISCHARGE/NURSING HOME DISCRIMINATION ON BASIS OF DISABILITY)

This 25 year old male Medicare patient was admitted to the hospital on 1/9 because of chest congestion and vomiting. On 1/18, he was discharged "in good condition" to the nursing home where he resided, according to the physician's discharge summary. Two and one-half hours later, he was readmitted to the same hospital because the nursing home said it could not provide the care he needed. He was readmitted under the same DRG, with the diagnosis being acute inflammation of the lung tissue.

Case Summary -- Patient 8

(MISLEAD PT ABOUT HER APPEAL RIGHTS)

On the day of her admission to the hospital, this 84 year old female patient was handed a "notice of termination of Medical benefits". She was informed that she would be "held responsible for the cost of further hospitalization during this episode of illness", effective two days later. Instead of describing her rights to appeal the denial, the hospital administrator advised her that "any concern you have about this denial of benefits...should be directed to: Secretary, Department of Health, Education, and Welfare, Washington D.C., and your Congressman."

Summary of Chronology/HCFA Inaction/PPS/Quality of Care

3/4/83 - House Conference Report on SSA amendments of 1983 expresses concern about premature discharge; would give Secretary additional authority to deny payment/terminate providers.

3/24/83 - Conference Report on SSA amendments of 1983 - Senate recedes to House provision.

7/83 - HHS/OIG alerts HHS Secretary of problem of premature discharges

10/1/83 - HCFA issues denial of payment and corrective action regulations.

5/18/84 - Proposed delegation of authority to implement statutory mandate to require hospitals to take corrective action.

5/24/84 - OIG legal analysis of Delegation of Authority.

10/15/84 - HCFA policy paper to address how HCFA can remedy the problems of hospitals "gaming" the PPS system and endangering lives through premature discharges, transfers. and inappropriate readmissions.

10/23/84 - HHS/OIG inspection report on abuse to Medicare beneficiaries occurring through premature discharges, inapproriate transfers and readmissions.

10/26/84 - HCFA's proposal on PRO policies for premature discharge, transfers and inappropriate readmissions.

1/18/85 - Letter from HCFA Administrator in response to HHS/OIG inspection report stating agreement that HCFA's instruction should be revised as soon as possible to require PRO's to make denials or require corrective actions.

Feb/March 1985 - Draft instructions on unnecessary readmissions and transfers

3/6/85 - IG draft legal memo on sanctioning authority.

3/29/85 - HCFAs redesignation of rule on denial of payment and corrective action as a result of admissions and quality review.

4/17/85 - HCFA issues regulations describing PRO review functions.

4/19/85 - Carolyn Davis states before Finance Committee that there is insufficient evidence to indicate any patterns of abuse.

6/19/85 - Secretary Heckler states in letter to Senator John Heinz that she has been assured that HCFA has not identified any pattern of poor quality under PPS to date.

CHRONOLOGY

HCFA's Inaction and Failure to Correct Problems: Premature Discharges & Inappropriate Transfers of Medicare Beneficiaries

March 4, 1983
House Conference Report No. 98-47 to accompany the Social Security Amendments of 1983.

"Because prospective payments will be made on a per admission/per discharge basis, your Committee is concerned that there may be an incentive for hospitals to increase their admissions or reduce the quality or availability of care. Accordingly, the Secretary would be provided with . . . additional authority to deny payment or terminate providers . . . "

March 24, 1983
Conference Report No. 98-47 on the Social Security Amendments of 1983.

"Under the House bill, the Secretary would be authorized to take corrective action. . . . The Secretary would be permitted to disallow part or all of the medicare payment with respect to an unnecessary or multiple admissions, or to require hospitals to take other corrective action necessary where a provider was determined to have engaged in such practices."

"The conference agreement follows the provision in the House bill with a modification which authorizes the Secretary to take such corrective action based on the findings of the PRO."

July 1983
Department of Health and Human Services Office of Inspector General begins to warn and alert HCFA of the problem of premature discharges and unnecessary transfers of patients under the Prospective Payment System of Medicare.

October 1, 1983
Department of Health and Human Services issues 42 CFR 405.472(e) - Denial of payment as a result of admissions and quality review regulations.

May 18, 1984
Memorandum from Don Nicholson, Assistant Inspector General for Health Financing Integrity, to Harvey Yampolsky, Office of the General Counsel. Subject: Request for Delegation of Program Authority -- ACTION

"Attached for your review is a proposed program delegation of authority which is necessary to implement the program integrity authority . . . . This authority permits the Secretary to make a determination that a hospital has taken actions which are intended to circumvent the prospective payment system and to require the hospital to take action to correct or prevent the inappropriate practices."

May 24, 1984

Memorandum from Thomas E. Herrman, Attorney, Inspector General Division, to Don Nicholson, Assistant Inspector General for Health Financing Integrity. Subject: Delegation of Authority under Section 1886(f)(2) of the Social Security Act.

Review of and comments on proposal to request the Secretary to delegate her authority to "make determinations . . . that a hospital has taken action 'to circumvent the (prospective) payment' system resulting in unnecessary hospital admissions or other inappropriate medical practices . . . and may deny payment for inpatient hospital services, or require the hospital to take corrective measures."

". . . we presume that HCFA's concurrence to the proposed delegation has been obtained."

October 15, 1984

Policy Paper entitled "PRO Policies for Premature Discharges, Transfers, and Inappropriate Readmissions"

Issue addressed: "How can HCFA remedy the problems of hospitals "gaming" the PPS system and endangering lives through premature discharges, transfers and inappropriate readmissions?"

Nature of problem: "We are becoming increasingly aware, through reports submitted to regional offices by PROs and through other anecdotal evidence, that some hospitals are circumventing the prospective payment system through inappropriate transfers, inappropriate diagnostic testing, and premature discharges, leading to readmissions. Although collection of actual cases and data analysis continues, we believe there is strong enough evidence at this point that inappropriate transfers, premature discharges and other inappropriate readmissions have occurred -- that patients have been harmed, and/or 'gaming' of the system has occurred."

Suggested Interventions - "It is the PRO's responsibility to take intervention commensurate with the nature of the provider's inappropriate action. We intend to include the following interventions in the scopes (sic) of work (and/or in administrative issuances) of all PRO contracts."

Intervention includes: "denial of the readmission or transfer" due to premature discharges or inappropriate transfers, intensified review of the physician's discharges and transfers, initiation of "sanction report and recommendation against a practitioner or provider for premature discharges or inappropriate transfers, loss of "Medicare certification status," and referral of cases of fraud and abuse to the Regional Office of the Inspector General.

October 23, 1984

Memorandum from Richard P. Kusserow, Inspector General, to Carolyne K. Davis, Ph.D., Administrator, Health Care Finance Administration. Subject: "Inappropriate Readmission and Transfer Practices under the Prospective Payment System --ACTION".

"The purpose of this Priority Inspection Report (PIR) is to alert you to a serious problem encountered during our ongoing review of the implementation of the Prospective Payment System (PPS)."

"I expressed my concern, as early as July 1983, that the Medicare program and its beneficiaries were vulnerable to abuse through medically inappropriate discharges, transfers and readmissions by hospitals under PPS. The Health Care Financing Administration (HCFA) provided assurances during the preparation of the PPS regulations that this problem would be handled by Medical Review Entities (MRE's) through the review of 100 percent of all readmissions and transfers and the denial of payment where appropriate."

"We find that evidence is mounting to suggest abuse of the PPS is occurring through . . . premature discharge . . of patients. As of July 31, 1984, 1130 of these cases have been identified by MRE's across the country. Additionally, our analysis of data . . . indicates that the actual number of cases may be significantly greater."

"The Health Care Financing Administration has the authority to deny payment or require corrective action on a case by case basis . . . Yet, it appears that HCFA may not be taking action when encountering these problems."

". . . the MREs, following present HSQB instructions, are not required to take corrective action on a case by case basis. We recommend that HCFA ensure corrective action is being taken by clarifying its instructions for the MRE's."

"Although the 1130 cases encountered to date might represent as much as $3.2 million of inappropriate payments, our major concern relates to potential patient abuses. The impact of this type of abuse on quality is so significant that its potential visibility could jeopardize the integrity of the medical review process and the payment system."

October 26, 1984

Memorandum from Allan Lazar, Director, Office of Medical Review to Associate Regional Administrators, Health Standards and Quality Regions I-X with attachment (see above) entitled "PRO Policies for Premature Discharge, Transfers, and Inappropriate Readmissions." The cover memorandum states that "the steps outlined in the paper are reasonable and legally supportable," and requests reactions and comments.

January 18, 1985
Memorandum from Carolyne K. Davis, Ph.D, Administrator, HCFA to The Inspector General, Office of the Secretary. Subject: Office of the Inspector General (OIG) Priority Inspection Report -- Inappropriate Readmission and Transfer Practices under the Prospective Payment System (PPS).

"We agree with the OIG report that HCFA's instructions should be revised, as soon as possible, to require PRO's to make denials or to require corrective actions, such as sanctions, in readmission and transfer cases involving medically inappropriate practices." " . . . we are developing program guidance which outlines specific situations and specific interventions that must be taken where inappropriate readmissions or transfers are identified."

February/March 1985
Draft/Proposed instructions on Unnecessary Readmissions and Transfers (IM 2080 - 2088)

March 6, 1985
Routing and Transmittal Slip from Tom Crane, Attorney, Inspector General Division, to Bart McCann, M.D., Office of Health Financing Integrity, with draft memorandum on Sanctioning Authority for Inappropriate Transfers Under PPS attached, under review by HCFA before final clearance.

March 13, 1985
Memorandum from Don Nicholson, Assistant Inspector General for Health Financing Integrity to Phil Nathanson, Director, Health Standards and Quality Bureau, HCFA. Subject: Draft Peer Review Organization (PRO) Instructions on Unnecessary Readmissions and Transfers -- INFORMATION.

Review of and comments on instructions on Unnecessary Readmissions and Transfers. Commenting on an issue not addressed in the instructions, Mr. Nicholson states, " . . . there have been over 2,000 cases referred by Medical Review Entities to HCFA regional offices. . . . these cases should be reviewed by the PROs and the appropriate action taken."

March 29, 1985
Department of Health and Human Services, Health Care Financing Administration. 42 CFR Parts 405 and 412. Final rule on Medicare Program; Prospective Payment System for Hospital Inpatient Services; Redesignation of Rules. Section 412.48 Denial of Payment as a result of admissions and quality review.

April 17, 1985
HCFA issues regulations describing the review functions to be performed by PROs. 74 Federal Register 15312 - Medicare and Medicaid Programs; Utilization and Quality Control Peer Review Organization (PRO): Assumption of Medicare Review Functions and Coordination with Medicaid. Final rule.

April 19, 1985

Statement of Carolyn K. Davis, Ph.D., Administrator, Health Care Financing Admistration before the Subcommittee on Health, Committee on Finance, United States Senate.

"PROs are reviewing the medical records of readmissions within 7 days of discharge and transfer to assure not only proper utilization, but also to determine that high quality care is not being compromised. Also, FIs review all transfers to hospital based skilled nursing facilities (SNF) and 30 percent of all transfers to nonhospital based SNFs to assure good quality care and proper utilization. Fewer than 200 cases have been referred to the regional offices so far. This number is insufficient to indicate any patterns."

June 19, 1985

Letter from Margaret M. Heckler, Secretary of Health and Human Services to Senator John Heinz.

"I have been assured that HCFA has not identified any pattern of poor quality care under PPS to date. However, HCFA has received some anecdotal information about isolated instances of poor quality (e.g., premature discharge and inappropriate transfers from acute settings to lower levels of care). In these cases, HCFA investigates thoroughly through the PROs and, where poor quality is identified, the PROs take corrective action against the facility or physician found to be at fault. Corrective actions could range from intensive review to exclusion from the Medicare program."

***Senator Heinz has corresponded with HCFA on numerous occasions between April 26, 1984 through June 19, 1985 on quality of care issues for Medicare beneficiaries.

***All emphasis added.

JOHN HEINZ, PENNSYLVANIA, CHAIRMAN

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United States Senate
SPECIAL COMMITTEE ON AGING
WASHINGTON, DC 20510

August 1, 1985

The Honorable Margaret M. Heckler
Secretary
Department of Health and Human Services
200 Independence Avenue, S.W.
Washington, D.C. 20201

Dear Madam Secretary:

I was delighted to learn from several of the peer review organizations (PROs) that the PROs have received within the last day or two from the Health Care Financing Administration (HCFA) the urgently needed instructions on how to handle inappropriate hospital discharges and transfers.

I am writing to commend and congratulate you and your Department for expediting transmittal of these important instructions in the interest of protecting and improving the quality of care for Medicare beneficiaries. As much as I regretted having to inform you on July 24, 1985 of HCFA's unfortunate 10 month delay in providing adequate instruction to the PROs, I am pleased that you were able to put these badly needed guidelines into the hands of the PROs in little more than a week.

I am sure that your speedy action will be greatly appreciated, not only by the PROs and their staffs, but also by health care providers and practitioners, as well as the thousands of Medicare hospital patients who hopefully can rest assured that they will not be wrongfully discharged or transferred from the hospital.

Madam Secretary, your quick action in the interest of protecting Medicare patients from recurring illness and life-threatening premature hospital discharge has, indeed, strengthened my resolve all the more to work with you closely in ensuring the integrity and success of the PROs and the Prospective Payment System.

Again, many thanks for your prompt action in coming to the aid of Medicare beneficiaries. May I also wish you a speedy recovery from your surgery.

Warm regards,

John

JOHN HEINZ
Chairman

DEPARTMENT OF HEALTH & HUMAN SERVICES

Health Care Financing Administration

The Administrator
Washington, D.C. 20201

AUG 9 1985

The Honorable John Heinz
Chairman, Special
Committee on Aging
United States Senate
Washington, D. C. 20510

Dear Mr. Chairman:

Several weeks ago, you held a press conference during which you alleged that HCFA had been misleading and manipulative in its presentations to Congress on the issue of ensuring high quality care for Medicare beneficiaries. I categorically deny and strongly resent your misrepresentation of the facts.

My staff and I have consistently been candid and open in testimony before the Senate Special Committee on Aging. With a spirit of cooperation born in common cause, we have allowed Committee staff full and free access to the files of the Health Standards and Quality Bureau. In their understandable zeal to uncover abuses of the system, the Committee has seized upon disparate statistics and misconstrued them to infer a suppression of evidence by this Administration. Nothing could be further from the truth.

We have maintained, and we continue to maintain, that while there have been ~~isolated~~ instances of premature discharge and inappropriate transfer, there has been no evidence of systemic abuse.

While attempting to show that HCFA has suppressed evidence on the magnitude of premature discharge and inappropirate transfer, you have used numbers that are both inaccurate and misleading.

In my April 19, 1985 testimony before the Senate Finance Committee I referred to fewer than 200 cases that had been reported to our regional offices so far. In my testimony, this number clearly represented only those cases referred to regional offices by fiscal intermediaries where there was a question as to the appropriateness of the discharge of a patient from a hospital to a skilled nursing facility; that is, the patient may have required continued acute care. On the basis of a review of a sample of these cases, HCFA regional offices are referring the cases to the appropriate PRO for further action--including sanctions.

You said at your press conference that the Office of the Inspector General cited 1,130 cases identified as of July 1984. HCFA physicians reviewed a sample of these cases and concluded that most were not inappropriate discharges but rather lacked appropriate documentation to explain the discharge or transfer. HCFA, believing that there was a potential for quality problems in this area, developed instructions for discharge and transfer.

You also said that: "Discharges and transfers red-flagged by the PROs are inappropriate and arise to 3,700 by March of this year." The actual number was 2,720 cases, however, these cases include readmissions for a wide variety of reasons including premature discharge; patient initiated discharge; and patients admitted for test, discharged, and later readmitted for surgery.

The instructions which we have issued direct the PROs to make appropriate denials where they identify a premature discharge or inappropriate transfer. These instructions were delayed, but not through lack of interest or neglect. They have been under consideration of intense, appropriate legal review within the Department. . That review has been concluded and the instructions have been issued.

We appreciate your expression of concern for the quality of care which our Medicare beneficiaries receive. But we will take second place to no one in our insistence that Medicare beneficiaries receive only necessary, appropriate high quality care. This is the primary purpose of peer reveiw—to ensure quality care.

The requirement that PROs deny payment for all premature discharges and inappropriate transfers is not negotiable. PROs must satisfy their contractual obligations or we will not hesitate to decertify them as we already have done with the PRO for the State of Pennsylvania.

I have enclosed, for your information, a list of PRO quality objectives and the results which the PROs are committed to achieve. You have my assurance that HCFA will continue to see that these objectives are met.

Sincerely yours,

Carolyne K Davis

Carolyne K. Davis, Ph.D.

Enclosure

PRO Quality Objectives

- Reduction in unnecessary hospital admissions resulting from poor care during prior admission.
  - Impact: 84,000 fewer admissions because of substandard care.
- Assurance that harmful underutilization of services does not occur and that postoperative and other complications are reduced.
  - Assuring provision of medical services that, when not performed, have significant potential for causing serious complications.
  - Impact: 32,000 fewer complications (includes reductions in postoperative complications).
- Reductions in risk of mortality associated with selected procedures and/or conditions requiring hospitalization.
  - Impact: 6,000 fewer mortalities.
- Reduction in unnecessary surgery or other invasive procedures.
  - Impact: 38,000 fewer unnecessary invasive procedures.

THE SECRETARY OF HEALTH AND HUMAN SERVICES
WASHINGTON, D.C. 20201

SEP 5 1985

The Honorable John Heinz
Chairman, Special
Committee on Aging
United States Senate
Washington, D.C. 20510

Dear Mr. Chairman:

Thank you for your long letter of July 24 which raised important public policy, philosophical and pragmatic questions about the way we are meeting our legal and humane responsibilities under the Medicare Hospital Prospective Payment System (PPS).

I appreciate your candor; I will do my best to match it.

Because of my personal and protracted involvement both in the draftmanship and in the implementation of the prospective payment system, I have an almost parental commitment to the quality of the services it provides to millions of Americans who are impacted by its day to day operations.

That is why we have placed such emphasis on the peer review organizations (PROs) — that is why I have watched their operation with such a careful eye. I was — I am — totally committed to such a "watchdog" concept and I am equally determined that the PROs have both 20/20 vision and "bite."

The Department starts from the premise that those we serve must receive quality care in a safe environment. We maintain a comprehensive, consolidated program to achieve those objectives. Only the providers and suppliers who meet our requirements and standards are eligible for reimbursement for care furnished to beneficiaries. Our certification process assures that only those hospitals and other health care providers who have the ability to provide safe quality care are eligible for Medicare participation. By closely monitoring the activities of the state survey agencies and with the help of respected accrediting bodies such as the Joint Commission on Accreditation of Hospitals, we are alerted to any significant deficiencies and we are then able to take immediate corrective actions.

The PROs are an integral part of this monitoring function. Each PRO is committed to achieving specific stated objectives in major areas of patient care quality. A listing of PRO quality objectives and the results which the PROs are committed to achieve is enclosed.

Where poor quality is identified, PROs take corrective and if necessary disciplinary action against the facility or physician found to be at fault. Our remedial arsenal is — in those instances — well stocked with appropriate "weapons" — exclusion from the Medicare program being the most severe.

Let me cite some specific examples of how the PROs have functioned:

One PRO, working with the state it serves, uncovered quality of care problems in a hospital. That hospital was closed. Another PRO has begun the sanction process on two physicians, one of whom endangered patients by late surgery; the other performed inadequate/inappropriate treatment. A third PRO has begun sanction activity on a physician who endangered patients by delayed surgery; a parallel probe intensified review on a physician who was performing procedures outside the orbit of his specialty. Still another PRO has intensified review for quality problems associated with pacemaker insertion by a cardiologist. As a result of that review, corrective action was taken; the doctor's performance has markedly improved.

Those are examples of both vigilance and decisiveness.

And we have taken a further, significant oversight step. HCFA has contracted with a medical auditor, known as the "Super PRO," to review a sample of cases from every PRO and to vigorously assess "performance." This will further broaden the scope of our PRO evaluation.

That kind of aggressive oversight policy has already resulted -- in your own state -- in the termination of the Pennsylvania PRO. HCFA has established a new PRO which is affiliated with the Pennsylvania Medical Society which will, we are confident, meet the highest performance standards. HCFA has also withheld funds from PROs in Massachusetts and New Mexico in order to enforce compliance with contract requirements.

As HCFA has assembled and analyzed the incoming mass of PRO data, we have formulated and now issued strengthened guidelines on denial of payment in cases where poor quality of care has been identified. Because we wanted those guidelines to be strong, clear, and unassailable from legal attack -- we subjected them to intense legal and public policy discussion and analysis within the Department. That process took time but we are convinced that the result is and will be fair and sound. Our work was not delayed by HCFA until January 1985, as suggested in your July 24th letter. The genesis of our program was, in fact, begun by a discussion paper which was circulated by HCFA in early December, 1984. Subsequently, the instructions went through careful analysis, review and several drafts, each circulated within the Department for comment. The final product was substantially improved through this process.

Your letter suggests indecision, inadequate preparation, and a lack of "grasp" by Dr. Carolyne Davis. In the more than two years that I was privileged to serve with her, I came to a conclusion about the quality of Carolyne Davis' work that is 180 degrees opposite from such a thesis. Carolyne Davis' integrity is quintessential; her commitment to the Americans HCFA serves has been nonpareil. She has been straightforward, candid and communicative with you and your colleagues in the Congress about Administration policies and practices. We have made our files available to the staff of the Senate Committee on Aging in the spirit of comity and cooperation.

Given that quantitative and qualitative cooperation, it is distressing indeed to find that your letter of July 20th cites "numbers" (in regard to premature discharges and inappropriate transfer) which are both incorrect and misleading.

In Dr. Davis' April 19, 1985, testimony before the Senate Finance Committee, she referred to fewer than 200 cases that had been reported to our regional offices as of that date. In that testimony, those cases clearly represented only those matters referred to regional offices by fiscal intermediaries where there was question as to the appropriateness of the discharge of a patient from a hospital to a skilled nursing facility; that is, the patient may have required continued acute care. On the basis of a review of a sample of these cases, HCFA regional offices are referring the cases to the appropriate PRO for further action — including sanctions. That procedure is consistent with the basic thrust of our ongoing efforts to protect patients from both medical error and cavalier treatment.

In your letter you contrasted the 200 cases mentioned by Dr. Davis with 1,130 cases that the Office of the Inspector General had identified as of July 1984. The two sets of numbers are not inconsistent because, as noted above, the 200 cases included only discharges to a skilled nursing facility. Moreover, HCFA physicians reviewed a sample of those cases and concluded that many were not inappropriate discharges but rather lacked appropriate documentation to explain the discharge or transfer. We did, however, believe that there was a potential for quality problems in this area and therefore developed the instructions for discharge and transfer.

There is another bedrock error in your letter of last month. It cites discharges and transfers red-flagged by the PROs as inappropriate as 3,700 by March 1985. The actual number was 2,720 cases. However, those include readmissions for a wide variety of reasons including premature discharge; patient initiated discharges; and patients admitted for testing, discharged, and later readmitted for surgery.

Your request for additional information and access to Department and PRO files is under review. I will respond to that request in the near future. I understand that, in addition, you have recently requested information from all ten of HCFA's Assistant Regional Administrators for Health Standards and Quality; the response to this request will be coordinated by HCFA's Central Office.

You and your colleagues on the special Committee are eloquent advocates for the millions of Americans we also serve. This Department has structured and is implementing an impressive system to improve the quality of care which Medicare beneficiaries receive. We welcome your counsel, your comments, and even your criticism as we go about that important task.

I will continue to insist that the PROs be strong, fearless, and intrepid as they serve young and old Americans alike. I welcome your partnership in that task.

Sincerely,

Margaret M. Heckler

Margaret M. Heckler

Enclosure

PRO Quality Objectives

- Reduction in unnecessary hospital admissions resulting from poor care during prior admission.
    - Impact: 84,000 fewer admissions because of substandard care.
- Assurance that harmful underutilization of services does not occur and that postoperative and other complications are reduced.
    - Assuring provision of medical services that, when not performed, have significant potential for causing serious complications.
    - Impact: 32,000 fewer complications (includes reductions in postoperative complications).
- Reductions in risk of mortality associated with selected procedures and/or conditions requiring hospitalization.
    - Impact: 6,000 fewer mortalities.
- Reduction in unnecessary surgery or other invasive procedures.
    - Impact: 38,000 fewer unnecessary invasive procedures.

THE SECRETARY OF HEALTH AND HUMAN SERVICES
WASHINGTON, D.C. 20201

OCT 2 1985

The Honorable John Heinz
United States Senate
Washington, D.C. 20510

Dear Senator Heinz:

In my letter of September 5 to you, I indicated the Department would provide further information relative to your concerns. I am pleased to forward to you now responses to questions you have raised. These are provided in the enclosure. I also assure you that the Department is continuing its commitment to the provision of high quality care to Medicare beneficiaries.

We will be happy to cooperate with your office and to honor any reasonable requests, as we have in the past. Members of my staff have previously communicated to your staff our policies regarding arrangements for meetings and the release of documents. To avoid undue disruptions, appointments must be made in advance, with at least 24 hours notice, and the length of time required, the subject matter to be discussed and any documents you require must be specifically identified.

You and your staff are welcome to meet with the PROs. Our relationship with the PROs is a contractual one. The contracts only require disclosure to the Department and to the General Accounting Office. Beyond this the contracts neither restrain nor require access to staff or documents, except for the restrictions imposed as part of our rule "Acquisition, Protection and Disclosure of Peer Review Information", published in the Federal Register on April 17, 1985.

Again, I appreciate your concern, which I share, for the quality of care provided to Medicare beneficiaries. I think you will find that the Department has taken appropriate action to assure that Medicare beneficiaries receive quality care in a safe environment.

Sincerely yours,

Margaret M. Heckler

Margaret M. Heckler

Enclosure

RESPONSES TO QUESTIONS RAISED IN JULY 24, 1985 LETTER

General

In the following, we believe we have been fully responsive to the substance of the questions. We will be happy to discuss individually any specific requests for further information. Data reported to us indicates no system-wide quality problems. PROs reviewed, through August 1985, approximately 2.5 million cases. Of that number only .148 percent were referred to HCFA Regional Offices as suspected premature discharges or inappropriate transfers. Even though we find no system-wide quality problem, we will see that strong action is taken where the PROs do identify quality problems either in an individual case or where a pattern exists.

Questions 1, 2, 3, 6 and 7

These questions deal with the Health Care Financing Administration's (HCFA's) instructions to the PROs on making denials, or requiring corrective actions, such as sanctions, in readmission and transfer cases involving medically inappropriate practices. Enclosed at Tab A is a copy of those instructions, which were issued to the PROs on July 25. Prior to issuing these instructions, HCFA consulted with the Office of the General Counsel (OGC). The Office of the Inspector General was also consulted and reviewed drafts of the instruction. Several difficult issues (e.g., the proper extent of PROs' authority to deny payment under Section 1866) required lengthy review which delayed the issuance of the instructions beyond the anticipated release date. Implementation will be more efficient and effective because of the careful analysis and resolution of these issues, and we are confident that our policies as implemented will survive potential programmatic and legal challenges.

Question 4

This concerned regulations changing the method by which transfer cases between PPS hospitals are paid. In the 1984 PPS update, published on January 3, 1984 (49 FR 234) HCFA announced that it was continuing to study the transfer situation. That statement was repeated in the August 31, 1984 final rule, (49 FR 34728), announcing the 1985 update, and in the September 3, 1985 final rule (50 FR 35646), announcing the 1986 update. Although it is the Department's intent to change the policy as Dr. Davis indicated, we cannot, at this point, give a firm date by which final regulations changing the transfer policy will be published.

Question 5

You asked why it took HCFA more than 12 weeks to respond to the OIG's October 1984 report on "Inappropriate Readmission and Transfer Practices under PPS." HCFA took this report very seriously and believed it deserved substantive response. To do so HCFA had to carry out various data gathering and analysis activities to determine the reasons for the readmissions and transfers (i.e., were they because of premature discharge or for other reasons as well). These activities had to be completed before an appropriate response could be made.

Question 8

You asked about Departmental evaluation of Medicare data to determine whether a two-week or one month threshhold for readmissions might identify more cases of premature discharge and poor care. Preliminary data show no "bulge" in readmissions occurring after the 7th day (see Tab B). However, in order to ensure that any problems are detected, we are seriously considering having PROs review readmissions within 15 days of discharge.

Question 9

You request the results of any HHS analyses to ascertain patterns of poor quality care, citing a figure of 3,700 cases of poor care. The 3,700 number used by the OIG was derived from all PRO referrals to the HCFA Regional Offices which appeared to be possible premature discharges or inappropriate transfers. A review of actual experience showed that during the time period to which the OIG estimates applied there were a total of 2,720 cases in which readmission occurred within 7 days of discharge or transfer to a lower level of care was found by the PRO to be questionable. This number includes readmission following earlier patient-initiated discharges (leaving against medical advice) and instances in which patients were admitted for tests, discharged, and subsequently readmitted for surgery or other inpatient services. Thus it reflects a larger universe than cases of questionable earlier discharge alone. Rather than conduct analyses to look for the kinds of patterns your questions suggest, we revised our guidelines for PROs to clarify their authority to deal with any instance of questionable quality of care. We believe this is a preferable approach, since most hospitals have not had such Medicare cases and those hospitals with reported cases have had few such cases.

Questions 10 and 11

Your questions requested information on attempts to calculate the number of deaths or serious and adverse patient outcomes that may be attributable to inappropriate readmission and transfer cases.

PROs review all readmissions within 7 days and all transfers. We do not make estimates of deaths or serious adverse outcomes related to inappropriate readmission or transfer; rather, the PROs investigate each case to determine if appropriate quality of care has been provided. We believe a broad focus encompassing all quality problems is more appropriate than the narrow focus you suggest.

Question 12

You requested the names of those PROs that seldom or never report adverse patient outcomes. We have enclosed at Tab C a copy of each PRO's referrals to the Regional Offices through May. Also enclosed at Tab C are the cases for each category where Regional Office referrals are requested. From these data, you can determine those areas which had been identifying few or no problems as of May. We should emphasize that none of these data in themselves identify adverse outcomes, but rather cases that require more intensified review. Regional Offices are now following through with PROs to assess the findings of such review as well as follow-up action; review by the Super PRO contractor should also help to bring to light any PROs that are not aggressive enough in acting on quality problems. We expect firm, decisive actions by PROs when they find instances of poor care. PROs that do not adequately carry out this responsibility will be non-renewed, or terminated. HCFA offices do not maintain onsite the primary documentation, i.e., medical records, review worksheet, quality review studies, etc. These documents are either kept at the PRO, its subcontractor, or at the provider.

Question 13

You requested the impact of PRO reviews to date under Quality Objective 1, broken down by individual PROs. We have already provided your staff with all PRO quality objective progress reports and also all current Regional Office monitoring reports (PROMPTs) of PRO performance.

Question 14

You asked whether the Department has compared baseline data on the incidence of poor care and premature discharge in 1983 (as reported by PROs) to current data. The earliest PRO contracts were awarded late in fiscal year 1984, therefore, there is no such PRO baseline data.

Questions 15 and 16

Your questions refer to two studies; however, the "Beneficiary Profiling System" which is described as a study in your question 16, is in fact a tool being used in the study you inquire about in question 15. This study is still in progress and final data or findings have not yet been developed.

Question 17

You request information on the ASPE/Urban Institute research project, as well as the status of each research proposal submitted to date to HCFA's Office of Research and Demonstrations (ORD) in response to its current grant solicitation. The final report of the ASPE/Urban Institute project on the feasibility and probable cost of studies to determine the impact of PPS on the quality of post-hospital care has not yet been submitted by the Contractor. However, we expect to issue the final report in the next few months. The Urban Institute has just been awarded an additional contract to determine how best to identify the relevant subpopulation, track its utilization of services, and evaluate the appropriateness of hospital discharges. This second study should be completed in one year.

Question 17(b)

With regard to HCFA's grant solicitation, the FY 1985 grant cooperative agreement solicitation published in the Federal Register on January 30, 1985 resulted in 163 applications. We are providing at Tab D documentation covering the 12 applications that deal with the impact of PPS on post-hospital care or the quality of post-hospital care.

Question 18(a)

You asked whether HCFA informed the Secretary of the contents of the OIG report. HCFA did not give the Secretary a copy of the OIG report.

Question 18(b)

We do not track cases referred on an individual basis (ancedotes) separately from those identified for PRO review activity through other means. PRO review of cases, whether as a result of individual referrals or other identification, is monitored by HCFA's regional offices. These offices quarterly sample every category of cases reviewed by PROs (using qualified medical personnel) to assure that findings are being properly made and necessary corrective action carried out. HCFA Central Office staff monitors this Regional Office activity.

Question 18(c)

You inquired as to what specific actions the Department has undertaken to notify beneficiaries of their benefits under PPS.

PPS did not change the benefit structure offered under the Medicare program. A pamphlet Prospective Payment For Hospitals Under Medicare was sent to all SSA offices for distribution to beneficiaries. HCFA also publishes an information newsletter, Medicare/Medicaid Notes, which is sent to the editors of magazines of 50 senior groups with very wide distribution. The September 1983 and May 1985 issues were devoted to PPS so that the editors could reprint the information on PPS in their organizational newsletters for dissemination to their members.

HCFA has published the pamphlet Your Right to Appeal Decisions on Hospital Insurance Claims in English and Spanish for dissemination through SSA offices and fiscal intermediaries. Also, the publication Your Medicare Handbook (also in English and Spanish) contains explanations of appeal rights in addition to the benefits offered under Medicare. This publication is sent to every new person enrolled under Medicare and is also disseminated through SSA and carrier offices, as well as HCFA regional offices. (All referenced documents are at Tab E.)

Question 18(d)

You requested the number of reconsiderations and appeals filed by Medicare beneficiaries under hospital, SNF, and home health agency Part A benefits. Enclosed at Tab F are charts reflecting statistical information from a computerized management information system that tracks data on completed Part A reconsiderations and hearings. Since the system did not become operational until the early part of 1983, we can only provide accurate data beginning with the first quarter FY 1984. There are ten regional charts listing the servicing intermediaries' individual quarterly output of reconsiderations and hearings through the third quarter FY 1985. The system does not accumulate data on intermediaries within each State because the program monitoring of appeals data is conducted on a regional level.

Question 19

You requested information on departmental notification to State survey and certification agencies of the illegality of certain forms of Medicaid discrimination.

Former Under Secretary Baker formed a Departmental Workgroup to study these issues. The workgroup has just recently finished its work, and has provided me a report with recommendations. I will give the report and recommendations my full and immediate consideration. You can expect to see the results of this effort in the very near future.

Question 20

You requested information on the long-term care ombudsman programs.

States are required under Section 307(a)(12) of the Older Americans Act to establish and operate Long-Term Care Ombudsman Programs. The State may operate the program directly, or by contract or other arrangement with any public or non-profit organization other than one responsible for licensing long-term care services in the State. In forty-one States, the State Agency on Aging administers the program. In thirteen States and the District Of Columbia, the program is operated by an agency other than the State Agency on Aging.

The functions of an ombudsman program include the investigation or resolution of complaints made by residents of long-term care facilities, establishing procedures for ombudsman access to facilities and patients' records, establishing a Statewide reporting system to collect and analyze data relating to complaints, and establishing procedures to assure client confidentiality.

The ombudsman programs are required to monitor the development and implementation of Federal, State and local laws, regulations and policies with respect to long-term care in the State. They also provide information to public agencies regarding the problems of older people in long-term care facilities. In addition to their work on investigating individual complaints, state ombudsman programs engage in a wide variety of activities related to program development. These activities fall into the following categories.

- On-going development and support of sub-state ombudsman programs through developing contracts and agreements with sponsoring organizations; providing basic ombudsman informational materials; training and certifying staff and volunteers; and maintain a statewide network by newsletters and meetings of local program directors;
- Publicizing the program and long-term care issues through the production and dissemination of consumer information

publications, such as residents' rights booklets, guides to nursing homes, brochures and posters on the program, and ombudsman appearances on the media;

- Serving on boards, committees and task forces dealing with long-term care issues;
- Promoting the development of residents' councils and community councils for long-term care facilities and providing training and technical assistance for council members.

While the Older Americans Act provides a legislative basis for all State ombudsman activities, a growing number of States have strengthened their programs through enactment of State statutes which provide specific State authorities for the programs. Twenty-six States have enacted ombudsman legislation.

Nationwide, over 1,000 paid staff and more than 5,000 volunteers work in the Long-Term Care Ombudsman program to investigate complaints, monitor regulations, provide information on ombudsman-related issues and provide for staff and volunteer training. The 1984 amendments to the Older Americans Act added a requirement that each State provide an individual on a full-time basis to carry on these responsibilities. Prior to 1984, there was no requirement for a full-time staff position.

The Older Americans Act requires each State to use an amount for Ombudsman purposes equal to the greater of $420,000 or 1 percent of its Title III allotment for supportive services. The requirement for using Title III funds does not apply in a fiscal year in which a State spends the required amounts from State or local sources. It should be highlighted that there is no limitation on the amount of Older Americans Act funds that may be expended on Ombudsman activities over the minimum amounts required. States are free to allocate funds in amounts which best support State and local priorities and for ombudsman programs.

In FY 1983 a total of $12.1 million Federal and non-Federal dollars were expended on ombudsman activities in State and substate programs: $8.9 million were Federal funds, and $3.2 million were non-Federal. From FY 1979 to FY 1984, grants were made available to State Units on Aging to assist them in establishing their long-term care ombudsman and legal services programs. The amount expended annually was approximately $2.8 million. These grants were made under Title IV of the Older Americans Act. States used funds under these grants to develop objectives, broaden local programs, secure State ombudsman legislation, and coordinate ombudsman and protective services.

Some of the activities conducted under these grants were: assisting State ombudsmen in investigating nursing home complaints; providing training and technical assistance in implementing substate programs; and coordinating the ombudsman program with other State agency activities.

To assist the States in further development and refinement of their programs, the Administration on Aging has provided technical assistance to State and substate ombudsman programs through issuance of a comprehensive manual. The manual is based on "best practice" of State and local programs, as identified by staff members of the former Bi-regional Resource and Support Centers, the National Citizens Coalition for Nursing Home Reform, the National Senior Citizens Law Center, and AoA staff. The twenty-one chapters include training of ombudsmen staff and volunteers, complaint documentation, consent forms, the role of volunteers, sample job descriptions, and fundraising.

In November of 1984, a national ombudsman conference conducted by the Administration on Aging was held in Philadelphia. There was 151 attendees including directors of State Aging Agencies, State Ombudsman, Regional and Washington AoA staff, and other agency representatives working in conjuction with ombudsman programs. Eight AoA Regional Offices and about twelve States have held follow up conferences.

Question 21

You asked what costs a beneficary incurs when a PRO denies payment to a hospital because of an inappropriate discharge or readmission, or when a SNF is denied payment because of too short a prior hospital stay.

If the PRO denies payment to a hospital for a readmission because the readmission resulted from a premature discharge from that hospital, the beneficiary would only be responsible for coinsurance payments for days after the 60th day in the spell of illness. No additional deductible would be required.

In accordance with section 1861(i) of the Social Security Act, "post-hospital extended care services" can be covered by Medicare only when a beneficiary was an inpatient for not less than 3 consecutive days before his discharge from the hospital. Therefore, irrespective of PPS and the PRO program, a beneficiary is liable for all costs incurred during a SNF stay that was not preceded by a qualifying (minimum 3-day) hospital stay.

JOHN HEINZ, PENNSYLVANIA, CHAIRMAN

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United States Senate
SPECIAL COMMITTEE ON AGING
WASHINGTON, DC 20510

October 7, 1985

The Honorable Margaret M. Heckler
Secretary
U.S. Department of Health
and Human Services
Washington, D.C. 20201

Dear Secretary Heckler:

I have followed with much distress your recent conversations with the White House and the subsequent announcement that you will be leaving the Department for Ireland. We have had our differences over the years. But in an Administration filled with budgeteers and number crunchers, yours has been a voice of balance, reminding us always of our primary reponsibility as public servants to the people, not the purse. You consistently have recognized that cost-cutting and social-consiousness often are in conflict.

The most recent stage for such conflict is the Medicare Prospective Payment System. Madame Secretary, you and I have agreed that inherent in PPS is the risk that the high quality health care paid for by 30 million Medicare beneficiaries might be sacrificed to cost containment. We have agreed that every appropriate action must be taken to prevent this from happening.

What we have not agreed upon, as evident in your letter to me of October 2, 1985, is that there are some serious flaws and deficiencies in the system and that the peer review organizations (PROs) are ill-equipped to provide any meaningful measure of quality assurance. Yet Madame Secretary, if you review the only real evidence at hand--the findings of an investigation by the Special Committee on Aging, and testimony before the Committee--no other conclusion is possible. Although your most recent letter makes no reference whatsoever to the tragic and alarming testimony before this Committee, I trust your staff who were in attendence will have thoroughly briefed you by now.

I believe the urgent need for action by DHHS is underscored by testimony from Medicare's own "watchdogs," the PROs themselves. The American Medical Peer Review Association (AMPRA), representing all 54 PROs, testified that the "present quality assurance system is limited, restrictive and lacks the innovation needed at a time when the incentives of PPS raise the potential for compromised care." The very organizations on which the Administration depends for monitoring quality of care said the Health Care Financing Administration's figures on premature discharges are unreliable and that older Americans are without the protection they so deserve.

Given the strength of this testimony, I must say that I am extremely puzzled by the comments of HCFA Acting Administrator C. McClain Haddow, in his October 2 appearance with me on the MacNeil-Lehrer Report.

Mr. Haddow rested his defense of the DRGs on the fact that "only a limited number--4,200" cases of questionable care have been reported by the PROs. What Mr. Haddow omitted from his statement is the fact that PRO reporting to date has been spotty and inconsistent. When questioned, he admitted that current reporting is limited to readmissions within seven days to the same hospital only. PROs do not review deaths from probable premature discharge. They do not review readmissions due to substandard care after eight days, or readmissions to a different hospital within any time frame. They do not track patients who are discharged to substandard nursing homes or to their homes without adequate support. And they have no record of the growing number of patients actually denied admission because of the inflexible diagnostic groups of the DRGs.

Madame Secretary, Mr. Haddow and the Health Care Financing Administration appear to suffer either from short-sighted focus which blurs some dangerous gaps and flaws in the PROs' quality assurance program, or a close-minded assumption that "see no evil, hear no evil, speak no evil" will be a palatable alternative to reform for the American people.

Testimony from health care providers, physicians and survivors of beneficiaries provided clear evidence that the deficiencies in the quality of care review have resulted in serious, and sometimes tragic, consequences.

Please find enclosed a copy of the Committee staff report, "Impact of Medicare's Prospective Payment System on the Quality of Care Received by Medicare Beneficiaries." I am confident that a personal review of this study will convince you of my point: Cost containment under the DRGs seems successful. We've softened the burden of health care on the pocketbooks of taxpayers, while lifting the threat of bankruptcy from the Medicare Trust Fund. But there are major problems with the system and it's past time we quit haggling over numbers and get down to the real business at hand -- reform.

As the Committee intends to pursue these problems to the fullest extent, it is essential for us to obtain any and all information concerning the impact of the PPS on quality of care. Therefore, I am requesting that you provide to the Committee staff by close of business on October 10, 1985, the report(s), draft and/or final versions, mandated by Public Law 98-21, Sections 603(a)(2)(A) and 605(b), concerning impacts of PPS and due on December 31, 1984 and 1985.

I would very much like clarification of another matter in your letter. The PROs are under the impression that the rule cited in your October 2, 1985 letter, "Acquisition, Protection and Disclosure of Peer Review Information" (42 C.F.R. Parts 400 and 476), applies to the U.S. Congress and, therefore, incorrectly believe that certain of their Medicare records cannot be shared with this Committee.

Contributing to the reluctance of the PROs to cooperate with this Committee and its ongoing oversight investigation is an August 28, 1985 memorandum prepared by Robert P. Jaye, Deputy Assistant General Counsel, DHHS, for Philip Nathanson, Director, Health Standards Quality Bureau, HCFA, which concludes that "disclosure of PRO information to a congressional committee is not authorized, and is, indeed, prohibited." (A copy is enclosed for your review.)

Notwithstanding Mr. Jaye's memorandum, it is my position that Congress' powers under Article I of the U.S. Constitution, as well as the language of Section 1160 of the Social Security Act, permit unrestricted access to any and all Medicare records maintained by the PROs. A general confidentiality provision in a statute cannot be applied to deny Congress information in light of Congress' well-established , Constitutionally-based power of oversight and investigation.

Moreover, Section 1160 of the Social Security Act provides a clear exception to the general rule prohibiting access to information held by the PROs. That section states that disclosure of PRO information is allowed to the extent necessary to carry out the purposes of the statute. The statute was enacted to ensure that efficient, effective and economical health care is provided to Medicare beneficiaries. As the purpose of the Committee's investigation is to guarantee proper medical care for Medicare patients, it is clear that PRO information cannot be withheld from the Committee.

I cannot emphasize too strongly that access to PRO records and data is essential to enable the Committee to effectively perform its oversight responsibilities. Therefore, I would very much appreciate your informing the PROs, as well as HCFA that the "Acquisition, Protection and Disclosure of Peer Review Information" regulations, which were published in the Federal Register on April 17, 1985, do not in any way restrict the PROs or HCFA from providing this Committee and its staff access to any and all Medicare records and documentation.

Madame Secretary, there is no more pressing problem in health care today than the threat to quality posed by the DRGs as they currently operate. As you prepare to leave the Department, I hope you will make reform of the system a top priority. I know of no greater legacy for you to leave behind than a program that effectively cuts costs as needed while protecting the patient as promised.

Sincerely,

John Heinz

JOHN HEINZ
Chairman

Enclosures

DEPARTMENT OF HEALTH & HUMAN SERVICES Office of the Secretary

Washington, D.C. 20201

OCT 10 1985

The Honorable John Heinz
Chairman
Special Committee on Aging
Senate Office Building
Washington, D.C. 20510

Dear Senator Heinz:

I am responding to your October 7 letter to the Secretary for certain documents to be delivered by October 10.

The short period from receipt of your letter is not sufficient to properly locate and identify all of the materials requested, especially those pertaining to certain reports required by Sections 603(a)(2)(A) and 605(b) of Public Law 98-21. Thus it will not prove possible to accommodate your request for the documents by October 10.

Sincerely yours,

for Lawrence DeNardis
Acting Assistant Secretary
for Legislation

JOHN HEINZ, PENNSYLVANIA, CHAIRMAN

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United States Senate
SPECIAL COMMITTEE ON AGING
WASHINGTON, DC 20510

October 17, 1985

The Honorable Margaret Heckler
Secretary of Health and Human Services
200 Independence Ave. S.W.
Washington, D.C. 20201

Dear Madam Secretary:

As Chairman of the Special Committee on Aging, I am requesting that you appear before the Committee on November 12, 1985 to provide testimony regarding the effects of the Prospective Payment System (PPS) on the quality of care delivered in-hospital as well as post-hospital to Medicare patients.

The purpose of this hearing, the third in the Committee's series of hearings on this issue, is to obtain an overview on how the quality of care under PPS may be improved in light of the evidence and testimony presented in the Committee's first two hearings.

The Committee is most interested in learning from you how Congress can assist the Department of Health and Human Services in assuring quality of care. I cannot emphasize too strongly the importance of your testimony to completing the record of the Committee's investigation. Specifically, I would very much appreciate your addressing the following issues:

1. In what ways can the role of the peer review organizations be expanded to oversee quality of care under PPS, both in-hospital as well as post-hospital?

2. What action does DHHS intend to pursue toward modifying the diagnosis related groups (DRGs) so that they are more sensitive to the differences in patients' severity and complexities of illness?

3. Please identify on-going DHHS studies designed to measure and assess the impact of PPS on quality of care for Medicare patients in the acute and post-acute settings, as well as those that are planned, and provide the dates on which on-going or planned studies are scheduled for completion.

4. Is DHHS exploring ways of improving grievance procedures associated with access to and quality of care for patients, providers and the PROs and, if so, what action has been taken in this regard?

5. In light of the increasing number of patients being discharged to the care of skilled nursing facilities and home health care agencies, what actions has DHHS taken to ensure access to these facilities and services for Medicare patients?

6. What are the findings regarding the effects of PPS in the DHHS analyses that were performed to respond to Public Law 98-21, which mandated certain reports to the Congress under Sections 603(a)(2)(A) and 605(b)?

7. What actions has DHHS taken to enforce laws prohibiting extortion and discrimination practices by nursing homes against indigent and severely disabled Medicare beneficiaries?

8. Overall, what are your thoughts and views on the findings and recommendations contained in Committee staff reports regarding the Committee's hearings on quality of care delivered in-hospital as well as post-hospital?

The hearing will be convened at 9:30 a.m. on November 12 in room SD-628, Dirksen Senate Office Building. Dr. Beth Fuchs of the Committee staff is available to provide whatever assistance you and your staff may need regarding your testimony. Should you or your staff have any questions, please have your staff contact Dr. Fuchs at 224-5364.

It would be very helpful if you could provide the Committee with 10 copies of your prepared testimony on November 10, 1985, and an additional 100 copies on the morning of November 12, 1985.

I look forward to receiving your testimony on these quality of care issues that are so vital to the security and wellbeing of older Americans.

Thank you for your cooperation and assistance.

Warm regards,

John Heinz

JOHN HEINZ
Chairman

JOHN HEINZ, PENNSYLVANIA, CHAIRMAN

WILLIAM S. COHEN, MAINE
LARRY PRESSLER, SOUTH DAKOTA
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DIANE LIFSEY, MINORITY STAFF DIRECTOR

United States Senate
SPECIAL COMMITTEE ON AGING
WASHINGTON, DC 20510

October 30, 1985

The Honorable Margaret Heckler
Secretary of Health and Human Services
200 Independence Avenue, S.W.
Washington, D.C. 20201

Dear Madam ~~Secretary~~ Peggy —

I am writing to share with you additional information and materials pertaining to the Committee's ongoing investigation of Prospective Payment System (PPS) impacts on quality of care for Medicare patients, both in-hospital and post-hospital.

I regret to inform you that the Committee's hearing last Thursday on "Medicare DRGs: Challenges For Post-Hospital Care" revealed yet another set of program flaws and deficiencies that unfortunately, and sometimes tragically, are impacting severely on the care of patients after hospital discharge.

Among the most significant findings from the Committee's October 24 hearing are:

1. The Health Care Financing Administration's own data show that, since the beginning of PPS, hospital discharges to skilled nursing homes have increased by 40%, and discharges to home health care, by 37%, resulting in the placing of unreasonable demands on families and community-based caregivers.

2. Home health care and nursing home care in the community is often unavailable or substandard.

3. Hospital discharge planners too often cannot meet the increased demands of the Prospective Payment System to ensure that discharged patients, still in need of heavy and round-the-clock nursing care, receive adequate attention.

4. Reimbursement rules on both the federal and state levels are based on "levels of care" that arbitrarily restrict the availability of nursing homes' services for patients in serious need of care, and fail to accurately describe patients' needs.

5. Significant changes and cutbacks in the Medicare home health benefit have placed unreasonable burdens on family members of patients.

I would very much appreciate your addressing these issues in your prepared testimony on November 12, along with the issues presented to you in my letter of October 17, 1985.

Please find enclosed copies of the testimony and Committee staff reports pertaining to the hearings conducted on September 26 and October 24, 1985. It is my hope that these materials will impress you with the gravity and severity of some of the problems that need to be corrected in order to ensure quality of care to all older Americans.

Again, I want to assure you of my sincere and abiding hope that the Department of Health and Human Services can join with the Special Committee on Aging in addressing program flaws and deficiencies as soon as they become apparent. I know that we both share the primary goal of making sure that Medicare patients do receive adequate and quality care while in the hospital and after they are discharged.

Should you have any questions regarding these and other issues raised in the Committee's investigation, please do not hesitate to call me. I very much look forward to your testimony on these matters so important to us all.

Warm regards,

JOHN HEINZ
Chairman

Enclosures

DEPARTMENT OF HEALTH & HUMAN SERVICES Office of the Secretary

Washington, D.C. 20201

October 31, 1985

MEMORANDUM FOR JAMES MICHIE

Jim, do you have a middle initial?

This is your lucky day. HCFA has agreed to turn over the draft of the response to the late-July letter of the Senator's, the draft being the one whibh came out of HSQB (Nathanson.) → its enclosed.

Tomorrow will be another lucky day, I predict. I have reason to believe that HCFA will turn over a box full of documents from the Regions on their contacts with PROs.

Next week may be lucky, too, but we'll have to see.

Hanns Kuttner

PS: Its hard to return calls to people whose switchboards aren't answered post 7 pm.

HK

The Honorable John Heinz
United States Senate
Washington, D.C. 20510

Dear Senator Heinz:

This is in response to your July 24 letter regarding quality of care under Medicare's Prospective Payment System (PPS). You are concerned that, despite the peer review organization (PRO) program, there are serious flaws in monitoring the quality of care provided to beneficiaries. In this regard, you raised several questions regarding the impact of PPS on quality care and the effectiveness of our implementation of PPS and PROs. The answers to these questions are contained in the enclosure.

In addition to your specific questions, you also requested that your staff be provided complete and unrestricted access to DHHS and PRO contractor personnel and documents. With regard to Departmental access, we will be happy to cooperate with your office and to honor any reasonable requests. To avoid undue disruptions, however, I must require that all requests for information be very specific (e.g., "we would like to speak with John Doe for one hour to discuss the May 15 letter to Ron Roe").

With regard to PRO access, as private corporations PROs are neither restricted from meeting nor required to meet with anyone, so access to PRO staffs is controlled by each PRO. As far as documents retained in PRO offices, the law specifies only the GAO as having unrestricted access. Our general counsel is reviewing the issue of which PRO documents would be disclosable to your staff.

Again, I appreciate your concern, which I share, for the quality of care provided to Medicare beneficiaries. I think you will find that the Department has taken every reasonable measure to assure the beneficiaries we serve receive quality care in a safe environment.

Sincerely yours,

Margaret M. Heckler

Enclosure

Prepared by:OMR:DRP:SAnderson/Nathanson:jg:8/14/85:Doc #3428C:

RESPONSES TO QUESTIONS RAISED IN JULY 24, 1985 LETTER

General

In the interest of a prompt response, and to conserve the time of staff engaged in implementing and evaluating PPS and PROs, we have answered the questions without the inclusion of the large number of internal memoranda, opinions, etc., referred to in the "Schedule of Questions". We believe we have been fully responsive to the substance of the questions. We will be happy to discuss individually any specific requests for further information.

Questions 1, 2, 3, 6 and 7

These questions deal with the Health Care Financing Administration's (HCFA's) instructions to the PROs on making denials, or requiring corrective actions, such as sanctions, in readmission and transfer cases involving medically inappropriate practices. Enclosed at Tab A is a copy of those instructions, which were issued to the PROs on July 25. Prior to issuing these instructions, HCFA consulted with the Office of the General Counsel (OGC) and the Office of the Inspector General (OIG). (It is standard procedure to obtain OGC clearance of sensitive issuances.) Several difficult policy issues (e.g., the proper extent of PROs' authority to deny payment under Section 1866) required resolution within the Department; this delayed the issuance of the instructions beyond the anticipated release date. Implementation will be more efficient and effective because of the careful analysis and resolution of these issues through intra-departmental coordination, and we are confident that our policies as implemented will survive expected programmatic and legal challenges.

Question 4

This concerned regulations changing the method by which transfer cases between PPS hospitals are paid. In the 1984 PPS update, HCFA announced that it was continuing to study the transfer situation. That statement was repeated in the proposed rule published on June 10, 1985, announcing the 1985 update. Although it is the Department's intent to change the policy as Dr. Davis indicated, we cannot, at this point, give a firm date by which when final regulations will be published.

Question 5

You asked why it took HCFA more than 12 weeks to respond to the OIG's October 1984 report on "Inappropriate Readmission and Transfer Practices under PPS." HCFA took this report very seriously and believed it deserved substantive response. To do so required HCFA to carry out various data gathering and analysis activities, which, of course, had to be completed and analyzed before an appropriate response could be made.

Question 8

You asked about Departmental evaluation of Medicare data to determine whether a two-week or one month threshhold for readmissions might identify more cases of premature discharge and poor care. Preliminary data show no "bulge" in readmissions occuring after the 7th day. (See Tab A.) However, we believe an increase in the amount of PRO review of readmissions may be appropriate in any case. We have proposed, in the draft scope of work for the next cycle of PRO contracts, to have PROs review readmissions within 15 days of discharge. (Of course, this proposal may be modified as a result of public comment or subsequent data analysis.).

Question 9

This involves "the approximately 3700 patients judged by the PROs to have received poor or inappropriate care." You request the results of any HHS analyses of these cases. There were actually 2720 such cases, which include readmission for a wide variety of reasons; not only premature discharge, but also patient-initiated discharge and patients admitted for tests, discharged, and later readmitted for surgery. (The July 25 instructions direct the PROs to make appropriate denials where they identify a premature discharge or inappropriate transfer.) There was no formal written analysis of these cases to share with you. However, informal analysis of a sample of these cases showed PROs needed more "clout" in dealing wih individual instances of questionable quality of care. Immediately, a HCFA physician began to develop the instructions that ultimately led to the July 25, 1985 issuance. It is simply inaccurate to conclude that HCFA did not respond properly to the cases identified by the PROs. It would also be inaccurate to conclude that these cases indicate a widespread or major quality of care problem, since they represent a very small percentage of the more than 83,993 readmissions reviewed by the PROs since their implementation between July 1 and November 15, 1984.

Questions 10 and 11

Your questions requested information on attempts to calculate the number of deaths or serious and adverse patient outcomes that may be attributable to inappropriate readmission and transfer cases. No such calculations are possible, since HCFA's data systems cannot capture outcomes not related to the utilization of Medicare benefits. We believe review of all readmissions and transfers, as well as discharges, is the most practical way to identify and force correction of serious quality of care problems.

Question 12

You requested the names of those PROs that are seldom or never reporting adverse patient outcomes. We have enclosed at Tab C a copy of each PRO's referrals to the Regional Offices through May. The PRO instructions state: "Submit questionable cases to the Regional Office if the reason for transfer is not apparent or is questionable; the readmission is covered yet the second stay is a result of premature discharge. Also enclosed at Tab C are the cases for each category where Regional Office referrals are requested. From these data, you can determine those areas which had been identifying few or no problems as of May. We should emphasize that none of these data in itself identifies adverse outcomes, but rather cases that require more intensified review. Regional Offices are now following through with PROs to assess the findings of such review as well as follow-up action; review by the Super PRO contractor should also help to bring to light any PROs that are not aggressive enough in acting on quality problems. We fully intend to require firm, decisive actions by PROs when they find instances of poor care. PROs that do not carry out this responsibility will be non-renewed, or terminated if their performance is poor enough. HCFA offices do not maintain onsite the primary documentation, i.e., medical records, review worksheet, quality review studies, etc. These documents are either kept at the PRO, its subcontractor, or at the provider.

Question 13

You requested the impact of PRO reviews to date under Quality Objective 1, broken down by individual PRO. We have already provided your staff with all PRO quality objective progress reports and also all current Regional Office monitoring reports (PROMPTs) of PRO performance.

Question 14

You asked whether the Department has compared baseline data on the incidence of poor care and premature discharge in 1983 (as reported by PROs) to current data. There are no such baseline data to compare. The earliest PRO contracts were not awarded until late in fiscal year 1984.

Questions 15 and 16

You requested information on a study to measure the impact of hospital PPS on home health agencies (HHAs) and skilled nursing facilities (SNFs), using the Beneficiary Profiling Systems. This study is still in progress and no final data or findings have been developed.

Question 17

you request information on the ASPE/Urban Institute research project, as well as the status of each research proposal submitted to date to HCFA's Office of Research and Demonstrations (ORD) in response to its current grant solicitation. The ASPE/Urban Institute project on the feasilibity and probable cost of studies to determine the impact of PPS on the quality of post-hospital care is completed and a final report is expected to be released in the next few months. The Urban Institute has just been awarded an additional contract to determine how best to identify the relevant subpopulation, track its utilization of services, and evaluate the appropriateness of hospital discharges. This second study should be completed in one year.

Input from ORD needed for 2nd
part of 17 (expected 8/16)

Question 18(a)

You asked whether HCFA provided me with a copy of the OIG report. I was provided with a copy of the report by OIG itself. HCFA, being aware of this, did not send me a duplicate copy. Your question seems to assume that HCFA did not respond to the cases identified by the PROs, or in the IG report. Neither assumptions are correct (see response to Question 8, above.)

Question 18(b)

You requested detailed information on anecdotal information about isolated instances of poor quality. We do not formally track those anecdotes after they are referred to the PROs.

Question 18(c)

You inquired as to what specific actions the Department has undertaken to notify beneficiaries of their benefits under PPS.

PPS did not change the benefit structure offered under the Medicare program. As stated in the 1983 pamphlet Prospective Payment For Hospitals Under Medicare:

> "Will Medicare prospective payment cause hospitals to cut costs by cutting services that should not be cut? The answer is no ***."

This pamphlet was sent to all SSA offices for distribution to beneficiaries. HCFA also publishes an information newsletter, Medicare/Medicaid Notes, which is sent to the editors of magazines of 50 senior groups with very wide distribution. The September 1983 and May 1985 issues were devoted to PPS so that the editors could reprint the information on PPS in their organizational newsletters for dissemination to their members.

HCFA has published the pamphlet Your Right to Appeal Decisions on Hospital Insurance Claims in English and Spanish for dissemination through SSA offices and fiscal intermediaries. Also, the publication Your Medicare Handbook (also in English and Spanish) contains explanations of appeal rights in addition to the benefits offered under Medicare. This publication is sent to every new person enrolled under Medicare and is also disseminated through SSA and carrier offices, as well as HCFA regional offices. (All referenced documents are at Tab D.)

Question 18(d)

You requested the number of reconsiderations and appeals filed by Medicare beneficiaries under hospital, SNF, and home health agency (HHA) Part A Benefits.

Input from BPO needed

Question 19

You requested information on departmental notification to State survey and certification agencies of the illegality of certain forms of Medicaid discrimination.

Under Secretary Baker formed a Departmental Workgroup to study these issues. The workgroup has just recently finished its work, and he has provided me a report with recommendations. I will give the report and recommendations my full and immediate consideration. You can expect to see the results of this effort in the very near future.

Question 20

You requested information on the long-term care ombudsman programs.

Input from Administration
on Aging needed

Question 21

You asked what costs a beneficary incurs when a PRO denies payment to a hospital because of an inappropriate discharge or readmission, or when a SNF is denied payment because of too short a prior hospital stay.

If a PRO denies a hospitalization and the beneficiary is not so informed prior to the services being provided, the beneficiary will be liable for only applicable deductibles and coinsurance, and charges for personal comfort items. If the beneficiary is informed prior to the provision of services that the services will not be covered, he/she will be liable for all charges.

In accordance with section 1861(i) of the Social Security Act, "post-hospital extended care services" can be covered by Medicare only when a beneficiary is transferred from a hospital in which he was an inpatient for not less than 3 consecutive days before his discharge from the hospital in connection with such transfer. Therefore, irrespective of PPS and the PRO program, a beneficiary is liable for all costs incurred during a SNF stay that was not preceded by a qualifying (minimum 3-day) hospital stay.

THE SECRETARY OF HEALTH AND HUMAN SERVICES
WASHINGTON, D.C. 20201

NOV 4 1985

The Honorable John Heinz
Chairman, Special Sommittee on Aging
United States Senate
Washington, D. C. 20510

Dear Mr. Chairman:

This is to acknowledge receipt of your letter of October 30, 1985, concerning the Committee's ongoing investigation of Prospective Payment System impacts on quality of care for Medicare patients, in-hospital and post-hospital.

I have asked the Acting Administrator for the Health Care Financing Administration to give your concerns prompt attention. We expect to provide you with a more thorough response in the near future.

Thank you for bringing this matter to my attention.

Sincerely,

Margaret M. Heckler

Margaret M. Heckler
Secretary

UNITED STATES OF AMERICA

Congress of the United States

To C. McClain Haddow, Acting Administrator, Health Care Financing Administration, U.S. Department of Health and Human Services, Washington, D.C., **Greeting:**

Pursuant *to lawful authority, YOU ARE HEREBY COMMANDED to appear before the* Special *Committee on* Aging *of the Senate of the United States, on* November 12 *, 19*85*, at* 9:30 *o'clock* a *m., at their committee room* SD-628 in the Dirksen Senate Office Building*, then and there to testify what you may know relative to the subject matters under consideration by said committee,* and to submit to the committee the documents and materials listed in the attached schedule.

Hereof fail not, *as you will answer your default under the pains and penalties in such cases made and provided.*

To James F. Michie, Chief Investigator, *to serve and return.*

Given *under my hand, by order of the committee, this* 8th *day of* November*, in the year of our Lord one thousand nine hundred and* eighty-five

Chairman, Committee on Aging

PAGE ONE OF ONE

Schedule of documentation demanded by the Special Committee on Aging, U.S. Senate, of C. McClain Haddow in a subpoena executed by H. John Heinz III, Chairman of the Committee, and dated November 8, 1985.

1. A copy of the draft and/or final report(s) mandated by Public Law 98-21, Sections 603(a)(2)(A) and 605(b) concerning impacts of the Prospective Payment System, which report was due for submission to the U.S. Congress in December 1984.

2. Copies of eight grant proposals and any and all correspondence, memoranda and other records pertaining thereto generated by the Health Care Financing Administration and offered to certain Peer Review Organizations for study of quality of care issues in Medicare and in the administration of the Prospective Payment System.

DEPARTMENT OF HEALTH & HUMAN SERVICES

Health Care Financing Administration

The Administrator
Washington, D.C. 20201

(NOTE: THIS LETTER WAS HAND-DELIVERED)
(TO CHAIRMAN HEINZ BY MR. HADDOW ON)
(NOVEMBER 12, 1985, IN RESPONSE TO A)
(SUBPOENA ISSUED TO MR. HADDOW BY)
(CHAIRMAN HEINZ ON NOVEMBER 8, 1985.)

NOV - 8

The Honorable John Heinz
Chairman, Senate Special Committee
on Aging
United States Senate
Washington, D.C. 20510

Dear Mr. Chairman:

Secretary Heckler has asked me to respond to your letter of October 7 in which you discuss your continuing concerns about the quality of care provided under the Prospective Payment System (PPS).

As you point out, the Committee and the Department share many common commitments. You are deeply concerned that Medicare patients receive high quality care; so is the Department. You believe that instances of poor care need to be detected and aggressively dealt with; so do we. You believe that the Peer Review Organizations (PROs) can and should focus more on quality issues; so do we.

Our efforts to work together constructively on these issues are impaired, however, so long as the discussion is based on polemics and the questioning of people's motives. For example, I don't think it advances our common objectives to suggest, as you did in your letter, that this Administration would jeopardize the well-being of beneficiaries in the interest of cost cutting. Our objective has always been, and will continue to be, to improve the cost-effectiveness of the system without sacrificing the quality of care. As I will outline below, we intend to strengthen the PROs' quality role in future contracts, and we support legislative action to expand PRO authority to deal more aggressively with quality problems.

Further, the Department has never taken the position that there are no flaws in the PPS, or that we are not concerned about instances of poor care brought to our attention, or that the only measure we use to gauge the extent of quality problems is the number of problems PROs identify in their review of readmissions within 7 days. What we have maintained is that studies of PPS impact need to be conducted with sound analytic methods, and that conclusions should be reached based on the review of facts. I think it does everyone an injustice to focus only on a few "horror stories." Indeed, there were horror stories before PPS and, unfortunately, one would expect there to be some horror stories no matter what the reimbursement system. Taking anecdotal information from a few cases and extrapolating it to the universe does a great disservice to the American people and the health care system in the United States. To conclude, on the basis of anecdotes, that PPS causes poorer care is not only invalid, it frightens the people of this country into believing that the care they receive under Medicare is inadequate. In fact, there is no data to support such a conclusion.

This is not to say, however, that we are satisfied with the present system of PRO review, or that we believe we have done all that can be done in quality assurance monitoring and enforcement. For example, in the second round of PRO contracts we intend to increase greatly the focus on quality areas. The Scope of Work now out for public comment makes several proposals:

- All cases reviewed by PROs would be screened by the PROs to determine whether generic indicators of possible quality problems are present. These generic indicators include, for example, nosocomial infection, unplanned return to the operating room, poor discharge planning and death.

- All Medicare readmissions occurring within 15 days (7 days in earlier contracts) of a previous discharge would be reviewed to assure that the patient was medically stable when discharged.

- A sample of all Medicare discharges would be reviewed to assure that they were not premature.

- Short stays (e.g., 1-2 days) would be reviewed to assure that the patient should have been hospitalized and was not released before being medically stable.

- Quality objectives would be sharpened up, based on more sophisticated data analysis, to focus on area-specific, hospital-specific, or procedure-specific quality problems.

In addition, we have made several changes to strengthen the current PRO contracts. For example, we are concerned that beneficiaries are properly informed of their rights concerning the effect of PRO review. To help assure that proper information is conveyed in a timely manner, HCFA is directing the PROs to provide specific language about the effects of PRO review (including appeal rights) to hospitals for inclusion in their notices to beneficiaries at the time of admission. And--because we recognize that the procedures for identifying premature discharges can be improved--we plan to fund premature discharge pilot projects in several States. The projects begin in November and will help us to augment our effort to stop premature discharges.

In short, I do not believe that the Department is trying to ignore or minimize quality-of-care problems. We share with the Committee a strong desire to improve the PPS, the PRO program, and the responsiveness of the Medicare program to the needs of the American people. We look forward to working together positively and constructively to achieve these goals.

Finally, let me deal with two specific requests in your letter.

You requested copies of the reports mandated by Public Law 98-21. The PPS Annual Report to Congress (Section 603(a)(2)(A)) will be delivered to the Committee for the November 12, 1985 hearing. The final Skilled Nursing Facility Benefit Under Medicare Report to Congress (Section 605(b)), which Secretary Heckler signed on April 16, 1985 and forwarded to the Congress, is enclosed for your information.

While I appreciate your desire to investigate potential abuses of the elderly to the fullest possible extent, the matter of access to patient records has serious implications relative to confidentiality and maintenance of patient rights. I have again referred your request to the Department's Office of General Counsel which will be looking into the legal issues involved. We will be in touch with you at a later date.

Sincerely yours,

C. McClain Haddow

C. McClain Haddow
Acting Administrator

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Responses to Senator Heinz's Letter of October 17, 1985 to the Secretary

1. Q. In what ways can the role of the peer review organizations be expanded to oversee quality of care under PPS, both inhospital as well as posthospital?

A. o PRO review will continue to be focused only on care provided in the inhospital setting during the next contracting cycle. We do not plan to expand PRO review beyond the inpatient hospital setting. The Federal government contracts with fiscal intermediaries which continue to review home health, outpatient, and nursing home claims.

o During the next contracting cycle, we are proposing to expand review to include:

- Readmissions which occur within 15 days of discharge from a PPS hospital. (Many PROs currently review admissions that occur over a period longer than 7 days.)
- Focusing review on discharges to assure that beneficiaries are not discharged before they are medically stable.
- Using generic quality screens for every case under review. This will make it easier for PROs to identify quality problems including premature discharges and poor quality care provided during the hospital stay.
- Reviewing all one- and two-day stays. We believe this focus on "short stays" will identify potential problems in utilization and quality.
- Adding a community outreach program to assure that beneficiaries receive adequate, accurate information on PRO functions.

o Complementary to the PRO program is the activity we undertake, through our certification process, to assure that providers which furnish poor quality care are taken to task. Termination as a Medicare provider can result from that process.

(NOTE: THIS SET OF RESPONSES WAS HAND-DELIVERED TO CHAIRMAN)
(HEINZ BY C. MCCLAIN HADDOW, ACTING ADMINISTRATOR, HEALTH)
(CARE ADMINISTRATION, ON NOVEMBER 12, 1985.)

2. Q. What action does HHS intend to pursue toward modifying DRGs so that they are more sensitive to the differences in patient severity and complexity of illness?

A. As announced in the Federal Register notices proposing, then finalizing PPS regulations for FY 1986, we will continue to refine the DRG system as we gain experience, and generally plan to alter it appropriately whenever PPS rates are updated or recalibrated. For newer technologies, we may want to move faster.

For example, in preparation for the 1986 PPS rates and regulations, HCFA has undertaken several refinements in the DRG Grouper Logic, surgical hierarchy and lists of comorbidities and complications that will improve homogeneity of case classification. In addition, in collaboration with the NIAAA, the DRGs for alchohol and drug abuse cases have been revised. We are also proposing refinements to incorporate newer technologies (percutaneous transluminal coronary angioplasty, lithotripsy, etc.) and to better reflect accepted medical practice (by adding a DRG for bilaterial or multiple major joint procedures of the lower extremity).

We will, of course, seriously consider each of the various ways by which DRGs might be refined to better reflect severity of patient condition and intensity of service as we develop our Report to Congress on this topic, which is due with the 1985 Annual PPS Impact Report. For example, the Rand Research Center is undertaking an assessment of the alternatives for improving Medicare case-mix measurement, and an assessment of the DRG system experience to date.

In addition to the activity being conducted by Rand, there are a number of other studies of proposed systems which attempt to better reflect patient severity and complexity of illness. The major efforts are as follows:

- Patient Management Categories -- Blue Cross of Western Pennsylvania (Wanda Young) expects to submit their final report and software this summer, and is continuing to study the feasibility of extending this system to outpatient department cases. The PMC's appear to be more clinically homogeneous than DRGs, however, a mechanism for classifying and valuing Medicare cases involving multiple categories needs to be delivered.

- Severity of Illness Index -- Johns Hopkins' (Susan Horn) final report from their study of Severity of Illness within DRG was submitted early this year. It is among the systems being assessed by the Rand Research Center. Other reviewers have noted that this system is costly to use (not standardized or computerized) and is somewhat subjective. However, it does appear to explain some of the difference in costs within DRG.

- Disease Staging -- The Department (ASPE) had undertaken several studies of the use of disease-staging within DRG as a means to reduce variance. Two Brandeis researchers reported in January that with some DRGs, disease staging increased variance, but reports from others (viz., Systemetrics) are more promising. Rand will be assessing this approach as part of its work meant to assist the December 1985 Report to Congress on DRG refinement.

- MEDISGRPS -- MEDISGRPS (Like the APACHE system which has been used to assess special care facility cases) uses biophysical signs, measures and test result changes from admission information and periodically thereafter to classify cases into severity categories. This commercially developed technique involves a larger amount of records maintenance and routine testing than most hospitals now employ, but appears to be highly objective. Rand assessments will also consider this approach.

- Nursing Resources -- The American Nursing Association is nearing completion of its study of DRG refinement for nursing care. Yale is nearing completion of the first year of its two year study of nursing resources by DRG. Both projects may identify DRGs where refinement may be most needed to better reflect nursing care requirements.

In September, HCFA awarded several new cooperative agreements for further research and case-mix refinement. Recipients included Systemetrics for further research on disease-staging, the Health Data Institute for development of a comprehensive integrated data base for use in comparing the performance of several refinement systems, Tulane University for a study of the performance of contending systems when used for cardiovascular cases, and Boston University for a study of case-mix differences in teaching versus non-teaching hospitals.

There are a number of factors to be considered as we study the merits and utility of each approach. Our preference is toward approaches which are founded upon the information contained in the uniform hospital discharge data set (UHDDS) or uniform bill requirements that are computerized, objective, verifiable and which do not induce "gaming."

3. Q. Please identify on-going DHHS studies designed to measure and assess the impact of PPS on quality of care for Medicare patients in the acute and post-acute settings, as well as those that are planned, and provide the dates on which on-going or planned studies are scheduled for completion.

A. On-going DHHS studies designed to measure and assess the impact of PPS on the quality of care for Medicare patients in the acute care setting consist primarily of the following:

Beneficiary Impact Study

The purpose of this internal HCFA study is to detect possible PPS effects on the quality of care by analyzing the outcomes of hosital care on the health status of the Medicare population, e.g., by analyzing mortality rates.

Results are currently becoming available and will be refined on an on-going basis.

Hospital Practice Study

This study will measure the quality related effects of PPS by examining hospital usage and treatment patterns and their effects on inpatient and discharge status. This study is being implemented through a cooperative agreement with the Commission on Hospital and Professional Activities (CPHA).

The final report is due in September, 1988, with interim reports due on an annual basis.

(Preliminary results attached)

Non-Intrusive Outcome Study

This cooperative agreement with the Rand Corporation is a long-term investigation into the feasibility of using Medicare administrative data to detect and monitor quality of care levels within individual hospitals for specific medical conditions.

The final report is due in December, 1987.

ESRD Study

This study focuses on the issue of whether the Medicare ESRD hospitalized patients, as a high cost treatment population, is being adversely affected by PPS, and is being conducted through a cooperative agreement with the Urban Institute.

Clinical Analysis of PPS Impacts on the Quality of Inpatient Medical Care

This study is an in-depth clinical analysis of PPS effects on the quality of inpatient care involving a cooperative agreement with the Rand Corporation and selected PROs across the Nation. The study will evaluate PPS impacts on quality by assessing potential treatment pattern effects and resultant health status outcomes through a thorough examination of the medical record.

The final report is due in September, 1988.

Recently funded research projects dealing with the PPS impact on the quality of care include the following:

Indexes of Hospital Efficiency and Quality

This cooperative agreement with CPHA is designed to produce a method for evaluating the relationship between quality and efficiency levels within hospitals, useful in measuring the combnied effects of PPS.

The final report is due in October, 1987.

Health Status at Discharge

This project is intended to develop and standardize a method for determining Medicare patients health status at the time of hospital discharge by assessing physical and mental functions and post-discharge treatment needs. This study is being conducted through a cooperative agreement with Northwest Oregon Health Systems.

The final report is due in July, 1986.

HOSPITAL PRACTICE STUDY
(CPHA)

PRELIMINARY FINDINGS

The following statistical comparisons are for Mediare hospitalized patients from 795 hospitals in non-waiver States, based on calendar year 3rd quarter data.

Overall Results

- Overall average length of stay (ALOS) fell between 1983 and 1984 at a rate significantly greater than the historic trend.

- Total discharges fell between 1983 and 1984 for the first time in 5 years.

- The greatest drops in average length of stay (ALOS) between 1983 and 1984 occurred in the Northeast PPS States.

- For surgical cases ALOS declined 1 day between 1983 and 1984, split about equally between pre- and post-operative days.

- Percentages of cases using the intensive care unit (ICU) declined between 1983 and 1984 from 9.6% to 8.7%; cardiac care unit (CCU) cases declined from 9.5% to 8.4%. ALOS for ICU and CCU were down slightly from 4.2% to 3.8% and 3.6% and 3.3%, respectively.

- Percent of discharges involving physician consultations remained about the same between 1983 and 1984.

- Severity levels (using CPHA developed indexes of severity) remained about the same between 1983 and 1984.

Conclusions

- Hospital utilization as measured by number of discharges and average length of stay has dropped under PPS.

- No preliminary indications that severity of hospitalized patients has changed under PPS.

4. Q. Is DHHS exploring ways of improving grievance procedures associated with access to an quality of care for patients, providers, and PROs, and if so, what action has been taken in this regard?

A.
- o HCFA is preparing language for a brochure to be given by the hospital to each beneficiary upon admission. This brochure contains information about what PROs are, why they exist, where they are located, what they do for Medicare beneficiaries, how they function, how their functions relate to patients, doctors, and hosiptals, and beneficiary appeal rights and responsibilities.

- o HCFA is also preparing model letters to be used by the PROs to inform beneficiaries of PRO denial determinations. These letters are tailored to the circumstances of the case and contain the following information:

  - A brief statement concerning the duties and functions of the PRO.

  - A reference stating that the PRO has discussed (or made every effort to discuss) the case with the attending physician.

  - The reason for the denial (e.g., services not medically necessary, or not appropriate for services to be provided in the hospital).

  - A clear statement as to whether the beneficiary is liable for payment for the denied services.

  - The reconsideration rights of the beneficiary, attending physician, and hosiptal, and where they can file for a reconsideration.

  We expect to issue these model letters to the PROs by the first of the year.

- o In addition to these efforts, HCFA is proposing to include a community outreach plan in the next round of PRO contracts. Through the community outreach program, the PRO will inform beneficiaries of the purpose and activities of the PRO program and assure that beneficiaries are aware they may contact the PRO if they believe they are not receiving appropriate medical care.

5. Q. In the light of the increasing number of patients being discharged to the care of skilled nursing facilities and home health care agencies, what actions has DHHS taken to ensure access to these facilities and services for Medicare patients?

A. It must be noted that health planning and certificate of need programs are administered at the State level and that regulation of the supply of services in States is not a Federal responsibility. We have no indication that the supply of home care and nursing home beds is inadequate. Access to the care by Medicare patients is assured by:

- cost reimbursement for home health and skilled nursing facility care so that a facility or agency will not lose money in providing covered care,
- waiver of liability provisions which provide payment even for noncovered care when it was provided through no fault of the facility or agency or patient,
- provider agreements which prohibit providers from discriminating against a patient on the basis of eligibility for Medicare.

We believe these factors provide an adequate safeguard to a Medicare beneficiary's access to care.

6. Q. What are the findings regarding the effects of PPS in the DHHS analyses that were performed to respond to P.L. 98-21, which mandated certain reports to the Congress under Sections 603(a)(2)(A) and 605(b).

A. The 1984 Annual Report on the Impact of PPS mandated by Section 603(a)(2)(A) of P.L.98-21 was forwarded to the Congress by Secretary Heckler on November 8, 1985.

The findings therein lead to several conclusions about the impact of PPS in its first year.

- o The new system appears to have been implemented smoothly, and to have encouraged substantial changes in the behavior of hospitals and other major groups within the health care sector. Many of these changes were anticipated by those who designed and enacted the PPS, although some changes particularly the drop in admissions, were not anticipated.
- o The rate of growth of Medicare benefit payments appear to have decreased under the PPS, led by the decline in inpatient hospital payments.
- o Furthermore, there is no systematic evidence thus far of declines due to the PPS in access to health care or in the quality of that care.
- o Thus, early evidence on the new system indicates that it is accomplishing many of its stated objectives, without any major problems.

The findings of the study performed under Section 605(b) indicate that differences in patient casemix appear to be one reason why hospital-based SNFs are more costly on average than freestanding SNFs. Other possible explanations for the cost difference include differences in quality of care and efficiency of operation. In addition, for Medicare reimbursement purposes, certain overhead or indirect expenses, such as administrative salaries, must be allocated between a hospital's acute care unit and subproviders such as the skilled nursing unit. Approximately 8 percent of total routine cost differences between hospital-based and freestanding SNFs has been determined to be due to overhead allocation in hospital-based facilities.

A difference in casemix between hospital-based and freestanding SNFs is indicated by Medicare utilization and staffing data as well as the results of most outside studies. The Medicare data indicated that hospital-based SNFs had, on average, higher proportions of Medicare patient days to total days and higher admissions per bed. Both of these results suggest higher utilization by short-term rehabilitation patients who are likely to be more costly to care for than traditional long term care patients.

On average, hospital-based facilities had 19 percent higher nursing hours than freestanding facilities. Hospital-based SNFs also provide more rehabilitation services than freestanding facilities. While these results suggest that hospital-based facilities are staffed to serve a more severe casemix, these data are insufficient to precisely isolate casemix effects from inefficiency and quality of care differences.

Results from six outside studies commissioned by HCFA also support the existence of casemix differences between hospital-based and freestanding SNFs. Evidence from these studies that the hospital-based faciilties tend to treat patients with greater severity of illness than do the freestanding facilities suggests that the higher costs associatecd with the hospital-based facilities are justified in part by the care needs of their patients. The results suggest that casemix differences may account for up to 50 percent of the cost differences between hospital-based and freestanding SNFs.

These findings are presented in greater detail in Chapter V of HCFA's Report to Congress: Study of the Skilled Nursing Facility Benefit Under Medicare, which was sent to Congress in April 1985.

It should be noted that the Deficit Reduction Act of 1984 effectively rescinded TEFRA's single reimbursement limits by providing that, for cost reporting periods beginning on or after October 1, 1982, and prior to July 1, 1984, "the cost limits for routine services for urban and rural hospital-based skilled nursing facilities shall be 112 percent of the mean of the respective routine costs for urban and rural hospital-based skilled nursing facilities." For periods on or after July 1, 1984, the Act specified that the reimbursement limits for urban and rural hospital-based SNFs respectively, should be equal to the sum of the corresponding limits for freestanding SNFs plus 50 percent of the amount by which 112 percent of the mean per diem routine service costs for hospital-based SNFs exceeds the limit for freestanding SNFs. In addition, the Deficit Reduction Act provided for the recognition, as reasonable cost, of the portion of cost differences between hospital-based and freestanding SNFs attributable to overhead allocation from Medicare reimbursement principles, notwithstanding the limits on routine service costs.

7. Q. What actions has DHHS taken to enforce laws prohibiting extortion and discrimination practices by nursing homes against indigent and severely disabled Mediare beneficiaries?

A. A Medicare certified hospital's awareness of requirements under Section 504 of the Rehabilitation Act of 1973 is assured in several different ways.

- Hospitals are requried to post, in a prominent place a poster supplied by the OCR that informs patients of their rights and where and how to file a complaint. This provides a constant reminder to hospital administration staff of their responsibilities under Section 504.
- Hospitals are given copies of all regulations concerning Section 504, including any changes as they occur.
- Hospitals are subject to compliance reviews performed by the regional office of OCR on an ongoing basis.

8. Q. Overall, what are your thoughts and views on the findings and recommendations cotnained in Committee staff reports regarding the Committee's hearings on quality of care delivered in-hospital as well as post-hospital?

A.
- o We agree with a number of ideas proposed by Committee staff to improve our quality assurance system. But we need to be sure that the American people understand three key points:
  - + There is no evidence that the new Medicare payment system has had a negative impact on the quality of health care for beneficiaries.
  - + We currently have in place Peer Review Organizations (PROs) to make sure that quality of care programs are identified and dealt with. Though the PROs are new and we and they are learning as we go along, we believe that their performance overall has been quite good.
- o Senator Heinz has accumulated a number of individual cases in which poor care appears to have been given, or patients discharged early. He is unable to estimate how extensive these problems are, but believes they are "more severe and widespread than current HCFA estimates." We believe problems are (1) not widespread at all; (2) generally reflect overall trends in health care, not impact of PPS.
- o For many reasons, the way health care is delivered in this country is changing rapidly--this is true for all patients and for all payment methods. Less and less care is being delivered in hospital beds or operating suites--but there is not evidence that care is worse as a result, or that the care given Medicare beneficiaries under PPS is different from, or worse than, care given other patients.
  - + We agree that it would strengthen PROs to have the authority to deny care because of poor quality.
  - + We agree that the second round of PRO contracts should focus more on quailty concerns and we plan to include specific quality review activities in the new Scope of Work, such as generic indicators or possible problems which will trigger corrective action where deficiencies in quality are found.

Responses to Senator Heinz's
October 30, 1985 Letter to the Secretary

1. Q. HCFA's own data show that, since the beginning of PPS, hospital discharges to skilled nursing homes have increased 40 percent and discharges to home health care by 37 percent, resulting in the placing of unreasonable demands of families and community-based caregivers.

   A. HCFA recognizes that the operation of the PPS has been accompanied by an increase in the number of discharges to SNFs and to home health care. We do not believe that there is evidence that this phenomenon has placed an "unreasonable" demand on families, skilled nursing facilities or home health agencies. In fact, to the extent that some hospital days have in the past been provided as a convenience to patients and their families rather than because they were medically necessary and appropriate, this is a desired effect on the PPS.

   The percents quoted appear to approximate the percent change in the percent distribution of reported discharge destination on PPS bills, not the percent change in SNF admissions. For example, in the first quarter of PPS, October-December 1983, almost 23,000 out of 511,000 (or 4.4 percent) of PPS discharges were reported as discharges to SNFs. For the quarter of January-March 1985, about 111,000 of over 1.8 million (or 6.0 percent) of PPS discharges were reported as discharges to SNFs. The percent change in the percent distributions was therefore 36 percent, close to the 40 percent figure quoted.

   However, SNF admissions have increased far less than 40 percent since PPS began based on admission notices sent in by SNFs, 141,000 Medicare enrollees were admitted to a SNF during October-December 1983 compared to 157,000 during October-December 1984, an increase of only 12 percent. For January-March 1985, 168,000 admissions were recorded, an increase of 20 percent. Prior to PPS, SNF admissions had been increasing 5 percent a year.

   The corresponding numbers for discharges to HHAs in the first quarter of PPS are 14,000 or 2.7 percent of PPS discharges and 69,000 or 3.7 percent in the January-March 1985 quarter.

   This represents a 37 percent change in the percent of discharges to HHAs from the October-December 1983 quarter to the January-March 1985 quarter. The percent change in total home health visits in 1984 was 7.7 percent, well below the 20 percent increases observed in both 1982 and 1983.

If the percent changes were calculated on the percent distribution of recorded PPS bills or PPS plus non-PPS bills combined, several points should be kept in mind:

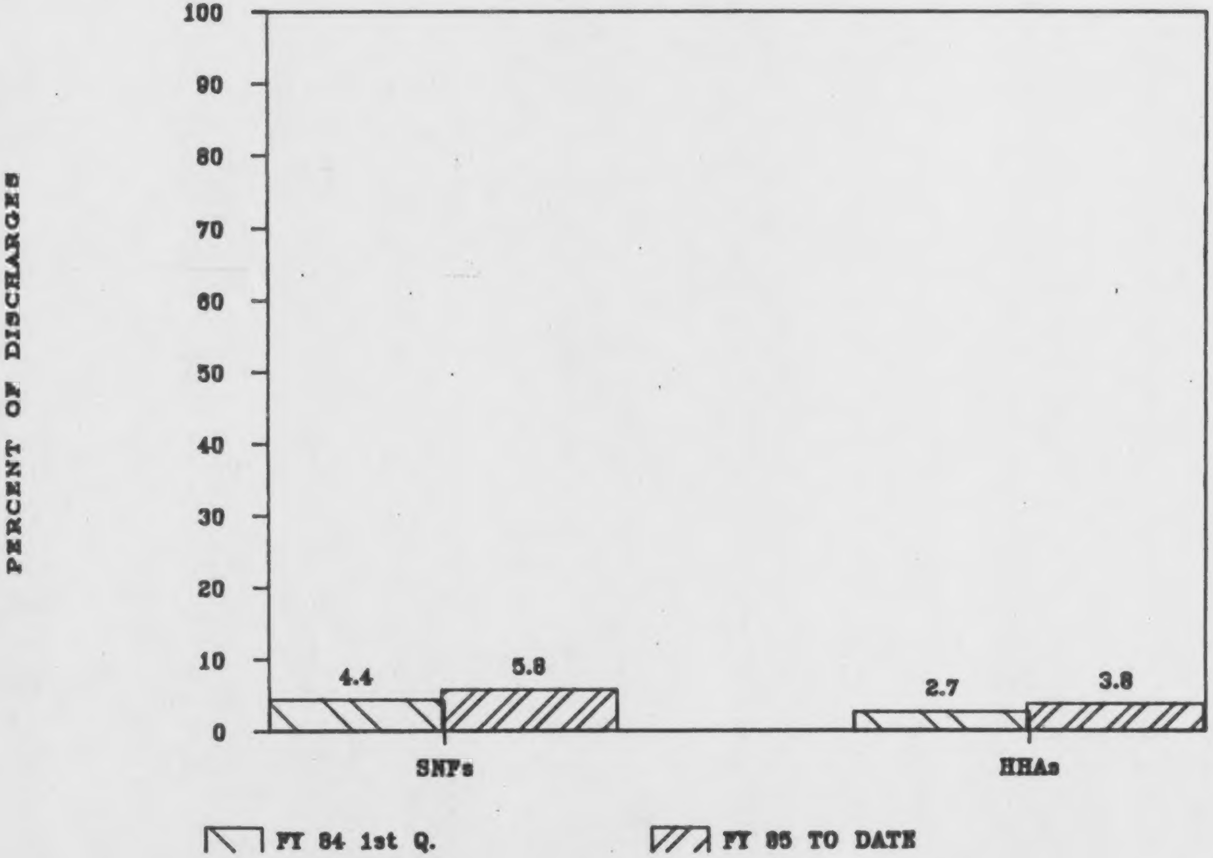
1. The percent change in a percent distribution does not mean that the number of discharges to a given category also changed by the same percent as the quoted data seems to imply.

2. The percent of discharges receiving long-term care could be expected to go up if fewer, and presumably, sicker on average, people are admitted. In fact, the hospital admissions declined in both 1984 and 1985. Thus resulting in a smaller denominator for computing the percent of discharges to long-term care facilities.

3. HCFA began collecting detailed discharge destination data October 1983. The quality of reporting, especially in the early months is uncertain. We do know that over 1/2 million non-PPS bills could not be properly allocated in FY 1984. The great majority of these (349,000) were for discharges during October-December 1983.

4. During the October-December 1983 quarter, relatively few bills were paid under PPS. We believe there was a strong geographical bias depending on the phasing-in of hospitals based on accounting years. The number of discharges to given categories and the resulting percent distribution for the first quarter will be affected by the delivery patterns in place in those areas.

PPS MEDICARE DISCHARGES TO SNFs & HHAs



2. Q. Home Health care and nursing home care in the community is often unavailable or substandard.

A. Nursing Home Care Availability

- Current data on the number of long-term care facilities which participate in Medicare and Medicaid indicate that there are approximately 17,000 skilled nursing (SNFs) and intermediate care (ICF) facilities nationwide. This universe has remained fairly constant over the past few years.
- Participation in either program is voluntary. Providers may and do change facility classification and program participation from time to time. This may affect the availability of either SNF or ICF beds in a community.
- If some communities are experiencing shortages in nursing home beds under either title XVIII or XIX, State health planning agencies and other State local agencies are available to work with hospitals, community planners, nursing homes and others to encourage the growth of nursing homes, convert oversupply of hospital beds to long term care beds or other methods to meet the needs of the community's population.

Substandard Care

- The conditions of participation for SNFs and standards for ICFs present the requirements facilities must meet to participate in the Medicare and Medicaid programs. These requirements address not only the facility's management and organization, environment, and fire safety, but set forth the regulatory expectations regarding the professional care and services the facility provides in order to meet the total needs of the patients (medical, physical, and psychosocial needs).
- State agency personnel perform surveys regularly to assess the extent and degree to which each facility is in compliance with these requirements. Surveyors may make additional unannounced visits to evaluate the status of problems or to investigate complaints.
- Problems the surveyors identify can result in the execution of a Statement of deficiencies for which the facility must submit a written plan of correction. Serious problems which threaten the health and safety of patients may lead to termination action as well as an imposition of bans on new admissions. We are presently in the process of developing the instructions to improve and clarify conditions under which these adverse actions can occur.

- We point to the absence of voluminous documentation depicting patient abuse and "substandard care" in the 1980s as opposed to the 1960s and early 1970s (congressional hearings).

- Both the industry and Federal survey and certification activities have grown and improved over the years. Our current activities in HCFA which are directed toward improving and refining the survey and certification process, including the development of a more patient outcome oriented survey form, would expect to culminate in even further lessening of instances of "substandard care."

Home Health Agency Availability

- We have no knowledge that beneficiaries seeking home health care have found it unavailable. Currently (as of October 9, 1985) there are 5,825 home health agencies participating in Medicare. A number of these have branches and subunits thereby increasing the areas in which HHA services are offered.

- The number of hospital-based home health agencies has increased dramatically from 507 in 1982 to 1,179 in 1985 (an increase of 132 percent). All agencies increased 60 percent during that period.

- The incrase in hospital-based home health agencies maximizes access to home health care for many Medicare beneficiaries making the transition from acute hospitalization.

- The Health Care Financing Administration has received very few complaints of substandard home health care. Any specific complaints dealing with allegations of poor quality are investigated by regional offices and/or State agency surveyors.

- We will begin to conduct visits to the homes of patients of HHAs to ensure that HHAs provide high quality services in accordance with the Medicare Conditions of Participation.

- All HHAs are surveyed for Medicare participation by State agencies under contracts with HCFA. These HHAs must meet specific regulatory conditions of participation that include provisions to ensure that all HHA services are ordered and reordered by physicians and in accordance with a specific plan of treatment for each patient. Also, all HHAs must employ qualified personnel and maintain records of services provided to individual patients.

3. Q. Hosptial discharge planners too often cannot meet the increased demands of the Prospective Payment System to ensure that discharged patients, still in need of heavy and round-the-clock nursing care, receive adequate attention. Please respond.

A. In response to these issues, we are opposing changes to the Hospital Conditions of Participation. These changes will strengthen and clarify discharge planning requirements under quality assurance. They specify that patients must be transferred to appropriate health care services for followup care.

4. Q. Reimbursement rules on both the Federal and State levels are based on "level of care" that arbitrarily restrict the availability of nursing homes services to patients in serious need of care, and fail to accurately describe patients' needs.

A.
- o It is inaccurate to say that level of care distinctions are a result of "reimbursement rules" if the implication is that HCFA and the administrators of State Medicaid programs have arbitrarily established them. Both title XVIII and title XIX have statutory distinctions between various levels of care and both statutes require a payment differential between them.
- o The distinction in levels of care is intended by law to reflect differences in the medical needs of the patients who are placed in the various facilities.
- o Neither Federal or State law prevents a facility from applying for certification as a skilled nursing facility or intermediate care facility if it meets the appropriate health, safety, and other standards.
- o Federal Medicare law and regulations provide for payment of the costs of a skilled nursing facility care and so payment rates should not have an effect on the quality of availability of care.
- o Federal Medicaid law and regulations require that State plans pay an amount sufficient to assure that both access and quality of care are available to Medicaid patients.
- o The Level of Care concept has been challenged by some critics (notably Bruce Vladeck in Unloving Care), however, it is still a central aspect of both the Medicare and Medicid statutes.

5. Q. Significant changes and cutbacks in the Medicare home health benefit have placed unreasonable burdens on family members of patients.

A. There have been no changes in home health coverage to which increased family burdens can be attributed. What has been taking place is a general improvement in HCFA's administration of the home health benefit. This improvement has included:

- consolidation, as ordered by Congress, of intermediaries processing home health claims,
- development of uniform forms for collecting information necessary to make home health coverage decisions,
- training of intermediary staff in the use of the forms and the application of existing coverage rules,
- proposed improvements in the way that Medicare's waiver of liability provisions would be implemented for home health agencies (but not final yet), and
- refinement of Medicare's statutory home health cost limits to focus more carefully on costs by discipline.

None of these changes has been a limitation on coverage. However, it is also true that the General Accounting Office advised us in 1981 that up to 27 percent of the home health visits Medicare paid for were not covered under the program. (MEDICARE HOME HEALTH SERVICES: A DIFFICULT PROGRAM TO CONTROL. HRD-81-155). While HCFA believed the estimate to be high, it agreed that improvements were needed. If denials of home health care have increased, we believe this is an appropriate result of imporved administration of current coverage rules. We do not believe that "cutbacks" or the operation of the PPS are the cause of any denials.

JOHN HEINZ, PENNSYLVANIA, CHAIRMAN

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United States Senate
SPECIAL COMMITTEE ON AGING
WASHINGTON, DC 20510

February 19, 1986

Honorable Richard P. Kusserow
Inspector General
Department of Health and Human Services
330 Independence Avenue, S.W.
Washington, D.C. 20215

Dear Mr. Kusserow:

As Chairman of the Special Committee on Aging, I am writing to request your assistance in the Committee's ongoing inquiry into the impacts of the Prospective Payment System on quality of care in the Medicare program.

Members of your staff briefed Committee staff on December 16, 1985 concerning the findings of your investigation into the incidence of premature and inappropriate hospital discharges and transfers. During that very helpful briefing, your staff informed Committee staff that a report on your investigation would be completed sometime in mid-to-late January 1986. I understand, however, that the report is still in draft form after having undergone several revisions over the past 60 days.

I anticipate that the findings of your investigation will shed valuable additional light on quality of care issues with regard to inappropriate hospital discharges and transfers, and will be helpful to this Committee as its members consider legislation to make necessary adjustments to PPS. Therefore, I am requesting that you provide the Committee with a copy, draft or final, of the report, "Inspection of Inappropriate Discharges and Transfers," by close of business on February 25, 1986.

Thank you for your cooperation and assistance in this important matter.

Sincerely,

John Heinz

JOHN HEINZ
Chairman

JH:jfm

INDEX II

INTERNAL DEPARTMENT OF HEALTH AND HUMAN SERVICES DOCUMENTS PERTAINING TO MANAGEMENT OF THE PROSPECTIVE PAYMENT SYSTEM

February 10, 1983 letter from John W. Miller, Executive Director, Alabama Peer Review Organization (PRO) to Senator John Heinz re: lack of recognition for accomplishments in improvement in quality of patient care.

May 8, 1984 memo from Don Nicholson, Assistant Inspector General for Health Financing Integrity, DHHS to Harvey Yampolsky, Office of the General Counsel of Inspector General, DHHS re: request for delegation of program authority—ACTIONS.

June 6, 1984 letter from John D. Abrums, M.D., President, American Society of Internal Medicine (ASIM) to Margaret M. Heckler, Secretary, Department of Health and Human Services (DHHS) re: quality of care problems under Prospective Payment System (PPS).

July 1, 1984 letter from Senator John Heinz to Charles A. Bowsher, Comptroller General, General Accounting Office (GAO) re: impact of PPS on services provided to older Americans.

July 20, 1984 letter from Carolyne K. Davis, Ph.D., Administrator, Health Care Financing Administration (HCFA), DHHS, to John D. Abrums, M.D., President, ASIM re: response to letter of June 4, 1984 concerning quality of care under PPS.

July 23, 1984 memo from Kenneth C. Schneider, M.D., Associate Regional Administrator for Health Standards and Quality, Region VI—Dallas, HCFA, DHHS, to Phillip Nathanson, Director, Health Standards and Quality Bureau, DHHS re: complaints of premature discharge.

August 24, 1984 memo from Allan Lazar, Director, Office of Medical Review, DHHS, to Kenneth C. Schneider, M.D., Associate Regional Administrator, Division of Health Standards and Quality, Region VI, HCFA, DHHS re: response to memo of July 23, 1984 regarding premature discharge.

August 29, 1984 letter from C.C. Kimsey, Action Associate Regional Administrator, Division of Health Standards and Quality, Region IV, HCFA, DHHS, to Allan Lazar, Director, Office of Medical Review, DHHS re: guidelines for pacemaker reimplants.

September 10, 1984 memo from Robert A. Cullen, Associate Regional Administrator, Division of Health Standards and Quality, DHHS, to Director, Office of Medical Review, Health Standards and Quality Bureau, DHHS re: case referrals to the HCFA Regional Office.

September 26, 1984 incidence report of North Dakota PRO to HCFA Regional Office.

October 23, 1984 memo from Richard P. Kusserow, Inspector General (IG), DHHS to Carolyne K. Davis, Ph.D., Administrator, HCFA, DHHS re: inappropriate readmission and transfer practices under PPS (attachment).

October 26, 1984 memo from Allan Lazar, Director, Office of Medical Review, Health Standards and Quality Bureau, HCFA, DHHS, to Associate Regional Administrators, Division of Health Standards and Quality, Regions I-X, HCFA, DHHS re: proposed policy for dealing with premature discharges and inappropriate transfers and readmissions (attachment).

December 28, 1984 letter from Fred Ferree, Executive Vice President, Iowa PRO, to Frank Kram, Regional Representative, Office of Health Financing Integrity, IG, DHHS re: review of a hospital regarding administration of unnecessary procedures.

January 4, 1985 Incidence Report from North Dakota PRO to HCFA Regional Office.

January 15, 1985 letter from Fred Ferree, Executive Vice President, Iowa PRO, to Ben Gruber, Division of Health Standards and Quality, Region VII, HCFA, DHHS re: contract modification to accommodate intensive investigation of a hospital (attachment).

January 17, 1985 letter from William E. Clark, Jr., M.D., President, Maine Society of Eye Physicians and Surgeons, to Michael A. LaCombe, M.D., State Director of Maine PRO re: concern about cataract surgery performed on an outpatient basis.

January 18, 1985 memo from Carolyne K. Davis, Ph.D., Administrator, HCFA, HDDS, to The Inspector General, DHHS re: Priority Inspection Report—Inappropriate Readmission and Transfer Practices under PPS.

January 29, 1985 letter from Kenneth E. Neff, Executive Director, Nebraska PRO, to Philip Gomez, Contract Specialist, HCFA, DHHS re: contract modification.

January 29, 1985 letter from Larry W. Pitman, Executive Director, Kansas PRO, to Elizabeth A. Faykus, Contract Specialist, HCFA, DHHS re: contract modifications for additional review.

January 31, 1985 Incidence Reports from North Dakota PRO to HCFA Regional Office.

February, 1985 report of referrals by Colorado PRO to HCFA Regional Office.

February 2, 1985 Incidence Report from North Dakota PRO to HCFA Regional Office.

February 6, 1985 letter from Fred Ferree, Executive Vice President, Iowa PRO to Burton Steckler, Contract Branch, HCFA, DHHS re: request for additional funds to perform review.

February 11, 1985 memo from Benny Gruber, Project Officer, Medical Review Branch, Division of Health Standards and Quality, HCFA, DHHS, to William J. Tate, Contracting Officer, Division of Procurement services, Contracts Branch, HCFA, DHHS re: contract modification for Iowa PRO.

February 21, 1985 letter from Eleanor Chelimsky, Director, Program Evaluation and Methodology Division, GAO, to Senator John Heinz re: information requirements for evaluating the impact of Medicare PPS on post-hospital long-term-care services.

March, 1985 PRO Manual, Interim Manual Instruction, HCFA, DHHS.

March 5, 1985 letter from William E. Clark, Jr., M.D., President, Maine Society of Eye Physicians and Surgeons, to Carolyne K. Davis, Ph.D., Administrator, HCFA, DHHS re: Diagnosis Related Groups.

March 6, 1985 memo from Mark Battista, M.D., Regional Medical Consultant, HCFA, to Cathleen McCarthy, Connecticut PRO re: draft of Connecticut PRO's Quality Objective "Reduction of the risk of preventable mortality from trauma" (attachment).

March 13, 1985 memo from Don Nicholson, Assistant Inspector General for Health Financing Integrity, DHHS, to Philip J. Nathanson, Director, Health Standards and Quality Bureau, HCFA, DHHS re: draft PRO instructions on unnecessary readmissions and transfers.

March 19, 1985 letter from Brenda F. Burton, Project Officer, Medical Review Branch, Division of Health Standards and Quality, DHHS, to Larry Pitman, Executive Director, Kansas PRO re: contract modification.

March 27, 1985 memo from Benny G. Gruber, Project Officer, Medical Review Branch, Division of Health Standards and Quality, HCFA, DHHS, to Allan Lazar, Acting Director, Office of Medical Review, Health Standards and Quality Bureau, HCFA, DHHS re: Iowa PRO contract modification.

March 27, 1985 memo from Allan Lazar, Director, Office of Medical Review, HCFA, DHHS, to Associate Regional Administrator, Health Standards and Quality, Regions I–X, HCFA, DHHS re: PRO contract workload.

April 3, 1985 letter from John W. Miller, Chief Executive Officer, Alabama PRO, to Mary Gregory, Project Officer, Region IV, HCFA, DHHS re: contract modification (attachment).

April 3, 1985 letter from Larry W. Pitman, Executive Director, Kansas PRO, to Elizabeth Faykus, Contract Specialist, HCFA, DHHS re: contract modification.

April 3, 1985 letter from Kenneth L. Neff, Executive Director, Nebraska PRO, to Philip Gomez, Contract Specialist, HCFA, DHHS re: contract modification.

April 4, 1985 Incidence Report from North Dakota PRO to HCFA Regional Office.

April 4, 1985 letter from Olympia J. Snowe, Member of Congress to Alton M. Paull, M.D., President, Rhode Island PRO re: performance of cataract surgery as outpatient procedure.

April 17, 1985 Incidence Report from North Dakota PRO to HCFA Regional Office.

April 23, 1985 letter from Michael A. LaCombe, M.D., Medical Director for Maine PRO, to Olympia J. Snowe, Member of Congress re: response to April 4, 1985 letter regarding outpatient cataract surgery.

May 1, 1985 Incidence Report from North Dakota PRO to HCFA Regional Office.

May 7, 1985 letter from Senator Christopher J. Dodd to Lawrence J. DeNardis, Office of Legislation, DHHS re: constituent letter regarding peer review process and denial of Medicare admissions (attachment).

May 8, 1985 letter from Robert A. Berry, President, Oregon PRO, to Don Tabor, Contracts Officer, HCFA re: contract modification.

May 9, 1985 letter from Burton Steckler, Contract Specialist, HCFA, DHHS, to Fred Ferree, Iowa PRO re: contract modification.

May 10, 1985 memo from Wanda Fields, Manager, Central Office Review, South Carolina PRO, to Regional Office, HCFA, DHHS re: referrals to Regional Office—premature discharges for month of April 1985 (attachments).

May 15, 1985 Nevada PRO contract modification.

May 17, 1985 letter from Philip J. Gomez, Contract Specialist, HCFA, DHHS, to Kenneth L. Neff, Executive Director, Nebraska PRO re: contract modification.

May 23, 1985 incidence report of North Dakota PRO to HCFA Regional Office.

May 24, 1985 memo from Thomas E. Herrman, Attorney, IG Division, DHHS, to Don Nicholson, Assistant Inspector General for Health Financing Integrity, DHHS re: delegation of authority under Section 1886(f)(2) of the Social Security Act (attachment).

May 29, 1985 letter from Gregory A. Lear, Chief, Medical Review Branch, Division of Health Standards and Quality, HCFA, DHHS, to Mohammad N. Akhter, M.D., Executive Vice President and Medical Director, Missouri PRO re: contract modification.

June 18, 1985 letter from Martin P. Margolies, Exective Vice President, New Jersey PRO, to Samuel Ford, Project Officer, Region II, HCFA, DHHS re: contract modification (attachment).

June 20, 1985 letter from Philip J. Nathanson, Director, Health Standards and Quality Bureau, HCFA, DHHS, to Senator Christopher J. Dodd re: response to letter of May 7.

June 24, 1985 memo from Robert E. Newhouse, M.D., Chairman, Rhode Island PRO Quality Review Committee, to Chairmen, Hospital Quality Assurance re: Quality Review Study I; readmission within seven days (attachment).

June 27, 1985 letter from Marianne Raimondo, Director, Quality Assurance, Rhode Island PRO, to Linwood Parsons, Project Officer, Health Standards and Quality Bureau, HCFA, DHHS re: revisions to the Quality Objectives (attachment).

July 17, 1985 incidence report of North Dakota PRO to HCFA Regional Office.

July 24, 1985 letter from Thomas E. Mangus, Director of Operations, Missouri PRO, to Greg Lear, Chief, Medical Review Branch, Health Standards and Quality Bureau, DHHS re: authority of PRO in instances of premature discharge and inappropriate admission.

July 30, 1985 letter from Fred Ferree, Executive Vice President, Iowa PRO, to Ben Gruber, Project Officer, Division of Health Standards and Quality, Region VII, HCFA, DHHS re: information requested on PRO quality of care assessment and corrective action.

July 31, 1985 letter from G. Rex Stone, Medical Director, Kansas PRO, to Brenda Burton, Project Officer, Medical Review Branch, Health Standards and Quality Bureau, Region VIII, HCFA, DHHS re: Quality Assurance Committee concerns and recommendations for quality review and reorganization structure for monitoring quality problems.

July 31, 1985 letter from Mohammad N. Akhter, M.D., Executive Vice President and Medical Director, Missouri PRO, to Greg Lear, Chief, Medical Review Branch, Health Standards and Quality Bureau, HCFA, DHHS re: quality problems identified by the Missouri PRO.

July 31, 1985 letter from Nancy L. Balmer, RRA, Manager of Review Programs, Nebraksa PRO, to Ben Gruber, Project Officer, Medical Review Branch, Division of Health Standards and Quality, HCFA, DHHS re: the screening of medical records for quality after patient discharge.

July 31, 1985 letter from Brenda Burton, Project Officer, Medical Review Branch, Division of Health Standards and Quality, HCFA, DHHS, to Larry Pitman, Executive Director, Kansas PRO re: results of Regional Office Monitoring visit.

July 31, 1985 letter from Robert A. Berry, President, Oregon PRO, to Don Tabor, Contract Specialist, HCFA, DHHS re: contract modification.

August 1, 1985 report by Trudi Galblum, HCFA Employee, DHHS re: Kansas PRO Quality Assurance monitoring visit.

August 1, 1985 Incidence Reports from North Dakota PRO to HCFA Regional Office.

August 1, 1985 transmittal letter for Annual Report from Margaret M. Heckler, Secretary, DHHS, to George Bush, Vice President, United States of America (attachment).

August 7, 1985 letter from Gregory A. Lear, Chief, Medical Review Branch, Division of Health Standards and Quality, DHHS, to Mohammad Akhter, M.D., Executive Vice President/Medical Director, Missouri PRO, re: specific actions PROs may take when a hospital has circumvented PPS.

August 8, 1985 transmittal from the Health Care Financing Administration to the United States Senate Special Committee on Aging, re: corrective actions PROs may take when a hospital circumvents PPS.

August 9, 1985 Incidence Report from North Dakota PRO to HCFA Regional Office.

August 9, 1985 letter from Thomas E. Mangus, Director of Operations, Missouri PRO, to Greg Lear, Chief, Medical Review Branch, Division of Health Standards and Quality, DHHS, re: screening of claims for statutory exclusions by Fiscal Intermediaries.

August 12, 1985 letter from Larry W. Pitman, Executive Director, Kansas PRO, to Bill Tate, Chief, Contract Branch, HCFA, re: contract modification.

August 15, 1985 memo from John W. Miller, Chief Executive Officer, Alabama PRO, to Administrators and Chiefs of Staff of all Alabama hospitals, re: prohibited actions which circumvent PPS (attachment).

August 15, 1985 letter from Edward J. Lynch, Executive Vice President, Rhode Island PRO, to Annette Kasabian, Chief, Office of Medical Review, Health Standards and Quality Bureau, HCFA, re: letter pertaining to peer review activities (attachment).

August 19, 1985 Incidence Report from North Dakota PRO to HCFA Regional Office.

August 20, 1985 letter from Edward J. Lynch, Executive Vice President, Rhode Island PRO, to Annette Kasabian, Chief, Office of Medical Review, Health Standards and Quality Bureau, HCFA, DHHS, re: PPS, medical review, and quality review (attachment).

August 21, 1985 letter from Gregory A. Lear, Chief, Medical Review Branch, Division of Health Standards and Quality, HCFA, DHHS, to Larry Pitman, Executive Director, Kansas PRO, re: clarification of PRO manual guidelines concerning unnecessary admissions, readmissions, and transfers.

August 22, 1985 Incidence Report from North Dakota PRO to HCFA Regional Office.

August 23, 1985 letter from Jerry B. Thompson, Project Officer for OMPRO, HCFA, to Larry D. Camp, Medical Review Branch, Division of Health Standards and Quality, Region X, HCFA, DHHS, re: Oregon PRO request for contract modification.

August 26, 1985 letter from Larry W. Pitman, Executive Director, Kansas PRO, to Elizabeth Faykus, Contract Specialist, Contract Branch, Division of Procurement Services, HCFA, DHHS, re: contract modification.

August 28, 1985 letter from Larry W. Pitman, Executive Director, Kansas PRO, to Elizabeth Faykus, Contract Specialist, Contract Branch, Division of Procurement Services, HCFA, DHHS, re: contract modification.

August 30, 1985 letter from Arja P. Adair, Jr., Executive Director, Colorado PRO, to James F. Michie, Chief Investigator, United States Senate Special Committee on Aging, re: PRO operations (attachments).

August 31, 1985 Report of the AMA Board of Trustees on DRG Monitoring Project.

September 6, 1985 letter from Ed Lessard, Chief, Medical Review Branch, HCFA, DHHS, to Regional PROs, re: quality review and premature discharge cases.

September 10, 1985 letter from Annette M. Kasabian, Chief, Medical Review Branch, Division of Health Standards and Quality, HCFA, DHHS, to Edward J. Lynch, Executive Vice President, Rhode Island PRO, re: disclosure regulations regarding impaired physicians identified through the peer review process.

September 6, 1985 letter from Andrew Webber, Executive Vice President, AMPRA, to C. McClain Haddow, Acting Administrator, HCFA, DHHS, re: unfavorable responses by HCFA to PRO requests for contract modifications.

September 9, 1985 memo from Clarence J. Boone, Associate Regional Administrator, Division of Health Standards and Quality, Region IV, HCFA, DHHS, to all PRO Contractors, Region IV, re: disclosure of PRO data to Congressional staff (attachment).

September 11, 1985 memo from Lawrence Osborn, M.D., Associate Regional Administrator, Division of Health Standards and Quality, DHHS, Boston Regional Office, to Director, Health Standards and Quality, HCFA, Baltimore, re: PRO identification of quality issues.

September 13, 1985 letter from Larry W. Pitman, Executive Director, Kansas PRO, to Brenda Burton, PRO Project Officer, Medical Review Branch, Division of

Health Standards and Quality, Region XII, HCFA, DHHS, re: effect of denied hospitalization on 3-day hospitalization requirement for skilled nursing coverage under Medicare.

September 17, 1984 outline of Quality Issues Protocol for the state of Maine, prepared by Rhode Island PRO.

September 17, 1985 outline of Quality Issues Protocol for the state of Rhode Island, prepared by Rhode Island PRO.

September 18, 1985 letter from Thomas G. Wallner, Associate Regional Administrator, Division of Health Standards and Quality, Region X, HCFA, DHHS, to Senator John Heinz, re: request for copies of PRO correspondence to Regional Office and HCFA responses concerning Medicare quality of care issues and PRO staff resources.

September 19, 1985 letter from Frederick S. Crisafulli, M.D., F.A.C.P., President, Rhode Island PRO, to participating physicians, re: medical review of Medicare beneficiaries.

September 23, 1985 letter from Brenda Burton, Project Officer, Medical Review Branch, Division of Health Standards and Quality, HCFA, DHHS, to Larry Pitman, Executive Director, Kansas PRO, re: skilled nursing transfer following initial hospital stay denial.

September 25, 1985 internal memo from Maine PRO pertaining to quality review problems and actions taken by the PRO.

October, 1985 flyer on PROs prepared by the Office of Beneficiary Services for Medicare and Medicaid Beneficiaries, HCFA, DHHS.

October 11, 1985 letter from John W. Miller, Chief Executive Officer, Alabama PRO, to James F. Michie, Chief Investigator, United States Senate Special Committee on Aging, re: additional comments on testimony of witnesses at September 26, 1985, hearing.

October 8, 1985 letter from Frederick S. Crisafulli, M.D., F.A.C.P., President, Rhode Island PRO, to participating physicians, re: case-by-case review of quality issues.

October 16, 1985 letter from Erma Wesley, ACSW, and Tammy Pentecost, LCSW, of the University of Alabama Medical Social Work Department, to James F. Michie, Chief Investigator, United States Senate Special Committee on Aging, re: case histories demonstrating negative impact of reimbursement system on patients and families.

October 21, 1985 letter from T. Reginald Harris, M.D., President, ASIM, to Senator John Heinz, re: results of survey on effects of PPS on quality of care (attachment).

October 24, 1985 letter from Henry C. Mostellar, Jr., M.D., President, Alabama PRO, to Senator Jeremiah Denton, re: shortcomings of HCFA data set as an indicator of quality of care (attachment).

November 8, 1985 letter from Margaret M. Heckler, Secretary, DHHS, to George Bush, Vice President, United States of America, re: report on general impact of PPS.

November 19, 1985 memo from Director, Office of Medical Review, Health Standards and Quality Bureau, HCFA, DHHS, to Associate Regional Administrators, Division of Health Standards and Quality, Regions I–X, HCFA, re: HCFA's policy regarding factors to be considered by PROs in making admission determinations.

November 25, 1985 memo from Richard P. Kusserow, Inspector General, DHHS, to C. McClain Haddow, Acting Administrator, HCFA, DHHS, re: inappropriate discharges and transfers under PPS.

November 26, 1985 memo from C. McClain Haddow, Acting Administrator, HCFA, DHHS, to Richard P. Kusserow, Inspector General, DHHS, re: inappropriate discharges and transfers under PPS (DHHS memo of November 25).

November 14, 1985 letter from Senator John Heinz to Eleanor Chemlinsky, Director, Program Evaluation and Methodology Division, GAO, re: request for comments on HCFA quality of care evaluations.

November 27, 1985 letter from physician to Senator John Heinz, re: "gaming" abuses by physicians and health care providers under DRG system.

November 29, 1985 letter from Joseph J. Hladky, Director, Office of Medical Review, Health Standards and Quality Bureau, HCFA, DHHS, to Associate Regional Administrators, Division of Health Standards and Quality, Regions I–X, DHHS, re: clarification of denial notice content and effective date of new procedures.

January, 1986 draft of report on Inspection of Inappropriate Discharges and Transfers, prepared by Richard P. Kusserow, Inspector General, DHHS.

February 26, 1986 letter from Vita Ostrander, President, AARP, to Senator Christopher J. Dodd, re: questions concerning quality of care problems under PPS.

ALABAMA MEDICAL REVIEW
1612 TENTH AVENUE, SOUTH
BIRMINGHAM, ALABAMA 35205

February 10, 1983

STATE
PROFESSIONAL STANDARDS
REVIEW ORGANIZATION

TELEPHONE
205/933-7229

Senator John Heinz
Chairman
Special Committee on Aging
Washington, D.C. 20510

Dear Senator Heinz:

An opportunity to respond to your letter of January 24, 1983 is appreciated. The physicians and staff of Alabama Medical Review, Inc. have become increasingly frustrated over the lack of recognition for accomplishments in what AMR considers to be the most important aspect of the PSRO/PRO program; improvement in quality of patient care.

The sanction process at AMR is a four step protocol (Enclosure I) in which increasing amounts of peer pressure are brought to bear on a physician until the AMR Board of Directors sends the physician our second sanction letter. The second sanction letter is the last peer review resort which proeceeds reporting the practitioner to DHHS for a sanction. To date, AMR's sanction process has always resulted in a modification in the physicians practice patterns or voluntary retirement from practice of medicine in the acute care setting on Federal patients. Enclosure II is a file of documentation on the most recent result of AMR's sanction proceess which went to the last resort of the second saction letter. While names have been removed to protect confidentiality, you can see that the physician in question volunteered to stop Federal practice in the actue care setting rather than have the sanction reported to DHHS. AMR's Board of Directors accepted this physician's offer (with verbal approval of the DHHS regional office) and he has stopped admitting Federal patients to the hospital. At any given time, there are usually several physicians involved in the sanction protocol, usually the intervention step. A listing of the number of sanction protocol actions for 1982 is in Enclosure III.

AMR, prior to loss of funding, had fully operational quality and medical necessity review programs in the 208 nursing homes of Alabama. The quality review process had identified and was in the process of conducting corrective interventions concerning quality of nursing home care in the various nursing homes of the state. This can best be illustrated by a summary of the study conducted in 1982 of patients transferred from nursing homes to acute care facilities. There were 166 nursing homes in the study. The sample included all patients transferred for a three month period. The total number of records reviewed was 1380. The criteria focused on physician and nursing care for a three day period prior to transfer to the hospital. The following statistics are of interest.

	Problem	Number of times the problem was documented
1.	Inadequate documentation of the medical record and lack of communication to the physician of pertinent patient information by the nurse.	326
2.	Failure of the nursing staff to recognize significant signs and symptoms requiring urgent or emergency treatment.	439
3.	Questionable drug orders	160
4.	Physician not available or unresponsive to reports by nursing staff.	145
5.	Hospitalization due to fractures/trauma which occured in the nursing home.	149
	TOTAL	1219

In addition there appears in many cases to be an inordinate amount of time lapse between identification of a problem requiring acute care attention and the actual transfer activities. These center around cumbersome notification tasks i.e. family members, physicians, supervisors, ambulance or private transportation arrangements.

There were numberous incidences of overutilization of PRN orders for sedatives and tranquilizers resulting in elderly patients being medicated to the point of confusion and oversedation.

The sadest and most frustrating element of loss of PSRO quality review in the long term care facilities is that the individual nursing homes are spending more tax money to do individual nursing home utilization review than was spent for PSRO review. By way of example; Alabama Qualtiy Assurance Foundation (AQAF is AMR's sister organization performing review in the private sector) is under contract to peform UR for twenty nursing homes, covering 1822 beds for $52,848 annually. Assuming that review performed by individual nursing homes is at least as expensive as AQAF group review of twenty nursing homes, its costs

$565,607 to review all 19,500 nursing home beds which is more than the cost of PSRO review. (AMR had $530,000 annually to do Medicare/Medicaid PSRO Review) Utilization Review, do it yourself review, has questionable quality impact compared to physician controlled and conducted, third party, PSRO review.

In closing, PSRO quality Review, in the acute and long term care setting, has been the only program to demonstrate physician accountability and an ability to provide positive physician to physician problems solving interventions into the quality of patient care. Your concerns for the quality of care provided by the Medicare and Medicaid Programs is encouraging when the current administrative position is to lower the cost no matter what the cost! Hopefully, through the concern and efforts of men like yourself, the PRO program will receive adequate funding to perform quality and utilization review in both the acute and long term care settings.

Sincerely,

ALABAMA MEDICAL REVIEW, INC.

John W. Miller
Executive Director

JWM:cgg

cc: AMPRA

DEPARTMENT OF HEALTH & HUMAN SERVICES
Office of Inspector General

Memorandum

MAY 8 1984

Don Nicholson
Assistant Inspector General for
Health Financing Integrity

Request for Delegation of Program Authority--ACTION

Harvey Yampolsky
Office of the General Counsel

Attached for your review and approval is a proposed program delegation of authority which is necessary to implement the program integrity authority contained under section 1886(f)(2) of the Act. This authority permits the Secretary to make a determination that a hospital has taken actions which are intended to circumvent the prospective payment system and to require the hospital to take action to correct or prevent the inappropriate practices. We have used the statutory language in our draft delegation.

After your review, this delegation of authority must be approved by the Secretary and published in the Federal Register. My staff will be happy to take the lead in drafting the cover note for the signature of the Inspector General and the Secretary. After this delegation receives final approval, we will submit a request to redelegate this authority to the Assistant Inspector General for Health Financing Integrity.

Barry Steeley of my staff would be happy to discuss this delegation with your staff in greater detail, if necessary. He may be reached on (FTS) 934-5034.

Attachments

Justification

On April 18, 1983 the Secretary delegated to the Inspector General the authorities under titles XI and XVIII of the Social Security Act to control fraud and abuse in Health Care Financing Programs. On April 20, 1983, the President signed into law Public Law 98-21, which provided for the Medicare Prospective Payment System for inpatient services. This law added section 1886(f)(2) to the Social Security Act, which gives the Secretary the authority to make a determination that a hospital has taken actions that are intended to circumvent the Prospective Payment System and to require that hospital to take corrective action. The statutory language under section 1886(f)(2) specifically states that the Secretary's determination must be based on the findings of a Utilization and Quality Control Peer Review Organization (PRO).

On September 1, 1983 the Department published regulations implementing the Prospective Payment System. Since PROs were not established at this time, the regulations provided that sanctions would be levied in appropriate cases against hospitals using the Office of Inspector General's sanction authorities under section 1862(d). Now that PROs are about to be established, it is appropriate to fully implement the authority contained in section 1886(f)(2) by delegating the expanded program integrity authorities contained in this section to the Office of Inspector General.

american society of internal medicine

June 6, 1984

Honorable Margaret M. Heckler
Secretary
Department of Health and Human Services
200 Independence Avenue, SW
Washington, DC 20201

Dear Secretary Heckler:

The American Society of Internal Medicine (ASIM), an organization representing physicians nationwide who specialize in internal medicine, would like to take this opportunity to voice its concerns about the apparent absence of any coordinated effort at the federal level to evaluate the effects of diagnosis related groups (DRGs) on the quality of patient care. During the debate preceding passage of the DRG legislation, ASIM and other medical groups repeatedly urged Congress to carefully examine the potential adverse effects on the quality of patient care before launching the program nationwide. ASIM's specific concerns were that the system could lead hospitals to: (1) underprovide services, (2) skimp on care in order to maximize profits, (3) artificially inflate diagnoses to obtain higher payment for the hospital (DRG creep), and (4) provide lower quality of care to Medicare beneficiaries.

Now that the system is being implemented across the country, ASIM is concerned about the apparent lack of any coordinated effort on a nationwide basis to document these possible adverse effects on the quality of patient care. It is vitally important that data be collected on patient mortality and morbidity, for example, so that the Department of Health and Human Services (DHHS) and Congress can properly evaluate the DRG program and make a decision, based on the results of this evaluation, on whether the program should be continued or modified. At a minimum, this should include a comparison of national morbidity and mortality rates for elderly (Medicare) patients of the "baseline" years preceding implementation of the prospective payment program with the rates following implementation of the program. A statistically significant increase--or decrease--in mortality and morbidity rates following implementation of the program would provide one indicator of its effects on quality.

The Department's study of extending DRGs to physicians' inhospital services also underscores the importance of collecting this data. Without information on how Medicare beneficiaries have fared under a DRG system for hospitals, it would be unwise for policymakers to consider extending this same system to physicians.

Because of these concerns, ASIM has initiated its own program to document the effects of DRGs--both positive and negative--on the quality of patient care. Internists across the country have been asked to complete the enclosed survey based on their experiences under DRGs. There is no deadline for submission of this form; rather, they are encouraged to make copies, completing and mailing them to ASIM as the need arises. Responses will be tabulated and any significant trends communicated to Congress and the Department.

ASIM believes that the collection of this data is a necessary first step in properly evaluating the effects of DRGs on patient care. This effort should be expanded, however, in order for policymakers to obtain an accurate picture of what changes in patient care, if any, are occurring across the country. The Society would like to know what plans the Department has to evaluate the effects of the program on quality of care. Specifically, we suggest that the Department consider implementing the following activities, if you have not already done so:

- Collect national data on mortality and morbidity rates, as suggested above;
- Survey (on a confidential basis) physicians, hospitals, and patients periodically to elicit their evaluations of the program's effects on availability and quality of care;
- Compile and report aggregate data and trends from Peer Review Organizations (PROs) on the number of hospital readmissions resulting from limited care and instances where the underutilization of services may have caused serious patient complications;
- Consider the development of research studies to compare the experiences of states under the national prospective payment program with states operating under a "waiver" from the program;
- Appoint a multi-departmental task force (with representatives, for example, from HCFA, the office of the Secretary, Centers for Disease Control, the National Center for Health Services Research, and/or other appropriate agencies) charged with developing a plan of action to obtain, coordinate and report to Congress and the public all appropriate information on the program's effects on quality and availability of care.

ASIM requests information on any plans by the Department to implement the activities suggested above and any other activities that are being considered to evaluate the effects of DRGs on patient care.

Sincerely,

John D. Abrums, MD
President

JDA/tlw
Enclosure

JOHN HEINZ, PA., CHAIRMAN

PETE V. DOMENICI, N. MEX.
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DIANE LIFSEY, MINORITY STAFF DIRECTOR

United States Senate
SPECIAL COMMITTEE ON AGING
WASHINGTON, D.C. 20510

July 1, 1984

Charles A. Bowsher
Comptroller General
General Accounting Office
441 G Street, N.W.
Washington, D.C. 20548

Dear Mr. Bowsher:

The Senate Special Committee on Aging is interested in evaluating the impact on the new Medicare PPS on services for older Americans. While the new payment system was intended to improve the efficiency by which Medicare acute services are provided, the Committee is particularly interested in assessing the impact of PPS on long-term care and other health services for the elderly. We believe that the magnitude and direction of these reimbursement changes are important to understand in order to assure older Americans of their continued access to quality health care.

We are pleased to see that the General Accounting Office's Program Evaluation and Methodology Division is currently working on a study which examines the possible effects of PPS on post-hospital sub-acute and long-term care services. We understand that your staff will be looking into the means by which the pressures exerted under PPS to reduce the length of hospital stays will affect Medicare costs, the use of Medicare covered skilled nursing facilities (SNF) care and home health care services, and more generally, the organization of Medicare sub-acute services. These changes have the potential to affect the quality of patient care and also the patient's ability to gain access to needed acute, sub-acute, and long-term care services.

Specifically, the Committee hopes that your study will:

- o Identify the range of issues regarding the likely impact of PPS on Medicare SNF and home health care services, as well as on other long-term care services.

- o Develop criteria to determine which of these issues are most important for federal evaluation efforts and apply these criteria to the range of issues to select a set of "priority" concerns.

- o Determine what data and information are and are not available to address these priority concerns and propose an evaluation plan to be used with specific data adequate to monitor and analyze these issues.

o Compare these plan specifications with the evaluation plan and data collection the Department of Health and Human Services (DHHS) intends to carry out, in order to determine how well DHHS' evaluation effort will answer the priority concerns.

The study should provide us with an analysis of the strengths and limitations of DHHS' planned efforts to assess the impact that PPS may have beyond the acute care system--specifically on Medicare SNF and home health care services and other long-term care programs. In addition, if improvements in DHHS' planned evaluation effort seem necessary, your analysis should provide information on the costs and feasibility of making such improvements.

This study should help to lay the foundation for issues that will need to be resolved in the future. It would therefore be helpful to the Committee to have the findings of your review presented in testimony at a hearing in the spring and more fully in a report to follow thereafter. If you have any questions, please call Ms. Tricia Neuman or Mr. David Schulke at 224-5364.

Sincerely,

John Heinz

JOHN HEINZ
Chairman

JH:tnl

BoT Report C

DEPARTMENT OF HEALTH & HUMAN SERVICES

Health Care Financing Administration

Attachment B

The Administrator
Washington, D.C. 20201

JUL 20 1984

John D. Abrums, M.D.
President
American Society of Internal Medicine
1101 Vermont Avenue, N.W.
Suite 500
Washington, D.C. 20005-3547

Dear Dr. Abrums:

Thank you for your June 4 letter to Secretary Heckler in which you expressed the concern of the American Society of Internal Medicine (ASIM) about the apparent absence of any coordinated effort at the Federal level to evaluate the effects of the Hospital Prospective Payment System (PPS) on the quality of patient care. The Health Care Financing Administration (HCFA) is committed to preventing any possible adverse impact of PPS on quality of care and is carefully monitoring the implementation of PPS to detect the first signs of such adverse impact if it occurs. HCFA is conducting efforts of two types in this area. I believe both will be of interest to you.

First, HCFA, as well as other agencies such as the National Center for Health Statistics (NCHS) and the Centers for Disease Control, collects data which may be expected to reflect the impact of PPS on quality of care. That data is, in general, being collected as part of other quality assurance and program management activities. For example, Peer Review Organization contracts which are soon to be awarded place a major emphasis on mortality and readmission rates. HCFA's routine analysis of hospital data places considerable emphasis on indicators of complication rates as well as mortality.

Second, the Office of Research in HCFA is obtaining, under a cooperative agreement with the Rand Corporation, a study to define how data which is now collected can provide valid indicators of the impact of PPS on quality of care and what new data might be collected for the same purpose. This study will guide the Department's analysis of data as the implementation of PPS proceeds.

Doi Report -
B.2

These efforts address specifically the five suggestions you have raised in your letter:

- NCHS currently collects national morbidity and mortality data using a variety of statistics; the Rand study will address how this data might be used to assess the effects of PPS on quality.

- The Rand study will address the utility of surveying providers and patients. This Adminstration is committed to reducing the Government's requests for data, and we would therefore generally favor less intrusive approaches. I know that ASIM has been in close contact with the HCFA Office of Research and trust that I can count on you to share the information which you develop in your study.

- The Peer Review Organization contracts specifically require that they study readmissions as an indicator of quality of care, and HCFA's Health Standards and Quality Bureau will be following these efforts carefully. The Rand study will address how this data may best be interpreted to measure the impact of PPS on quality of care.

- Through a contract with Clark Abt Associates, HCFA conducted studies comparing quality of care in the "waivered" States with quality of care in other States before PPS was put in place; these studies showed no difference in quality of care. The Rand study will be carefully reviewing the extension of these same measures to a comparison of waivered and unwaivered States. However, the systems in place in the waivered States generally resemble the PPS system, so that it is not likely that differences reflecting the implementation of PPS will be observed.

- At this point I believe that Departmental efforts are sufficiently appropriate and well coordinated to make appointing a Departmental task force unnecessary. However, we will keep your suggestion in mind as data begin to become available.

Of course, it is still much too early to document the impact of PPS on quality of care. A substantial fraction of the nation's hospitals are not yet on PPS, and it will be 6 to 12 months after all are on before even preliminary national impact data is available. Nevertheless, we share your Society's interest in assuring that PPS does not have adverse effects on quality of care and we will be analyzing the pertinent data intensively as it becomes available.

Sincerely yours,

Carolyne K Davis

Carolyne K. Davis, Ph.D.

[July 23, 1984 Memorandum]

Health Care Financing Administration
Region VI - Dallas

Complaints of Premature Discharge

Philip Nathanson, Director
Health Standards & Quality Bureau

With increasing frequency, this office is receiving inquiries from Social Security District offices and others on behalf of beneficiaries and families with complaints of premature discharges from hospitals. The Social Security district offices are requesting guidance on how to handle such allegations and where to refer these complaints for further investigation.

After discussing this issue with the various components of the Regional Office, we have determined that there is no clear or consistent mechanism existing for the referral and investigation of allegation of premature discharge. As a complaint of premature discharge usually involves a quality of care issue, the logical referral of such allegations would be to the MRE. However, our evaluation of the requirements of the PRO RFP has not identified a requirement for the PRO to perform such a function. Although the RFP includes general statements regarding the PRO function to review the "completeness, adequacy, and quality of care provided," there are no specific instructions related to investigation of such issues other than that which is performed in the course of required review activities. Further the RFP discussion of abuse issues appears to restrict the PRO to evaluating only specific "cases submitted by HCFA, OIG or the Medicare fiscal agent." Although development of sanctions is clearly a PRO function, the RFP implies that this function is only relevant once a potential violation has been identified. It would seem to be presumptive to assume that the development of sanctions includes investigation of generic complaints.

Given that nothing is to be assumed under the fixed price PRO contract, it would appear that functions not specifically identified in the contract cannot be required without additional negotiations. Investigations of complaints/allegations of premature discharge have not been so identified and therefore, it would be improper to advise referral of such complaints to the PRO.

We would appreciate your advising this office if the above interpretation of the PRO responsibility in this situation is correct. Further, if you concur with the above, would you please advise if any recommendations will be forthcoming as to the proper referral of these incoming complaints?

Kenneth C. Schneider, M.D.
Associate Regional Administrator
for Health Standards & Quality

bcc: originator/official/reading files
KCS/JDS/JJP
HSQB/PSROB/MNicholson/ab/7/20/84/76301

Dr Schneid

CG
DS
JJP
RSE
WDW
~~SM~~
AB

DEPARTMENT OF HEALTH & HUMAN SERVICES

Health Care
Financing Administration

Memorandum

①

cc: JDS
BM

JN
WB
MN
VR

AUG 24 1984

Director
Office of Medical Review

FILE CODE:

Complaints of Premature Discharge--Your ~~Memorandum of July 23~~

Kenneth C. Schneider, M.D.
Associate Regional Administrator, HSQ
Region VI

Thank you for bringing to our attention the inquiries you have received from Social Security district offices regarding complaints of premature discharges from hospitals.

I apologize for the delay in getting our response to you. We agree that the appropriate entity to receive such complaints would be the Professional Review Organizations (PRO). However, we also agree that since PRO contracts do not specifically contain requirements for review of premature discharges, we cannot require PROs to investigate these individual complaints.

We believe, however, that PROs can address themselves to complaints of premature discharge in the following ways:

1. The Social Security district offices should refer the complaints to the HHS Office of the Inspector General (OIG). The OIG will in turn refer the case to the PRO for evaluation.
2. If a PRO detects a pattern of abuse, it should initiate the sanction process.
3. If a PRO detects a pattern of abuse, it may develop a quality objective to correct the problem and negotiate a change in its contract with HCFA.

If you have any questions, please contact Kay Terry on 8-934-7910.

Allan

Allan Lazar

DEPARTMENT OF HEALTH & HUMAN SERVICES

Health Care Financing
Administration

Region IV
101 Marietta Tower
Atlanta GA 30323

Joanna

August 29, 1984

Mr. Allan Lazar, Director
Office of Medical Review
Health Care Financing Administration
1849 Gwynn Oak Avenue
Baltimore, Maryland 21207

Dear Mr. Lazar:

Re: 516-PRO Review Activity Report Form

One of our PROs called concerning the "Draft" instructions for completing the monthly 516 PRO Review Activity Report item IV.B Procedure Review-Pacemaker Reimplants (see Attachment A). Attachment B (page 60 of the "Draft") instructs PROs "...do not include the replacement of electrodes or generator packs only; a reimplant is defined as the total replacement of the old unit with a new one." (Emphasis added). We believe all situations: pulse generator and/or lead replacements should be reported by the PRO as a reimplant. We cannot comprehend why Central Office would define and restrict a reimplant to the total unit--both the pulse generator and the lead, because this deviates from what happens in the real world and virtually eliminates most reimplant reporting.

Earlier pacemakers consisted of three separate pieces of hardware: the pulse generator (commonly referred to as the pacemaker), the battery and the lead. More recently with the discovery of the more powerful lithium battery, the pulse generator and lithium battery are hermetically sealed to form a single unit. This not only reduces infection, but also eliminates the patient's annual trek to the operating table for a 'battery' change because the life expectancy of the pulse generator now ranges from two to seven years.

The lead is the second part of the pacemaker currently being used. The lead contains the electrode. Most leads contain a redundancy feature: there is always one or two good conductors left in one strand of the lead if one part should break or weaken. Moreover, adapters are available that enables one manufacturer's leads to be compatible with a pulse generator from another manufacturer. This eliminates unnecessary lead replacement when a different pulse generator is reimplanted. In fewer cases, the lead is the problem. Usually this is not discovered until surgery. In most of these cases, the pulse generator as well as the lead is replaced. Under your draft instructions these few cases are all that will be reported by the PRO. We believe the definition of reimplant should be "replacement of pulse generator and/or lead."

We have an observation about another section of this same report. Page 6 of Form 516, the PRO gathers warranty information about newly implanted or reimplanted pulse generators. Not all manufacturers offer warranties, as they are not required. The warranties that do exist include so many limitations that they are rendered worthless. Moreover, during a reimplant situation, the old warranty (if there was one) is the one that would apply. Rarely is this warranty available or benefits applied for. How then, does this data collection benefit the Medicare program? We realize that this data collection effort is part of the contract signed by all

PROs but if the process has outlived the need for the data, HCFA should eliminate the requirement.

In a Program Validation Study of fifty pacemaker reimplant patients conducted by us less than one year ago, we demonstrated that at least ten percent of the payments for pacemaker reimplants is due to factory recalls (Medicare's expense of the pulse generators, leads and attendant services totalled $52,579.66 by the hospital and $3,615 in surgeon's charges in our sample cases alone). The Food and Drug Administration is a good source for this recall information. A factory recall is a place where HCFA could pursue financial retribution by these companies where Medicare patients are concerned. This is an area where HCFA could demonstrate real dollars recovered. Perhaps the PRO collected data could be useful in this endeavor.

Please let us know what is decided about the "Draft" instructions concerning the definition of reimplants.

Sincerely yours,

Regina E. Williamson, for
C. D. Kimsey
Action Associate Regional Administrator
Divison of Health Standards and Quality

The notices of costs denied for cost outlier cases should identify each service denied and differentiate between charges denied based on medical necessity or appropriateness and those denied because the service was duplicatively billed, not rendered, or not ordered or involved a technical denial under 4(a) above. Those costs denied based on medical necessity, or appropriateness of the health care services require that the beneficiary be notified of each service denied and these denials are subject to the limitation of liability provisions of the Act.

Services which are duplicatively billed, not rendered, or not ordered by the physician, and technical denials made under 4(a) above should be denied as noncovered care. Such denials do not constitute determinations requiring notice to the beneficiary and are not subject to limitation of liability provisions. A notice explaining such denials of costs must be sent to the hospital and to the fiscal intermediary.

C. Sanctions.--If a pattern of unnecessary outlier days or services within a particular hospital meets the definition of a substantial violation in a substantial number of cases or a gross and flagrant violation, the PRO must develop a sanction recommendation in accordance with the Federal regulation at 42 CFR Part 474.

IM 2050.3 Invasive Diagnostic and Therapeutic Procedure Review

The performance of invasive diagnostic and therapeutic procedures may affect DRG classification, thus leading to increased reimbursement. Therefore, PROs will be required to establish review for procedures other than those procedures identified for preadmission review in the PRO contract.

A. Permanent Cardiac Pacemaker Implantation Review.--All PROs must review permanent pacemaker insertions and reinsertions.

1. Identification.--Identification of cases for pacemaker review should be based at a minimum upon ICD-9-CM codes for permanent pacemaker implantations and reimplantations. Review does not apply to temporary pacemakers.

2. Review Requirements.--Every case involving permanent pacemaker insertion (including permanent pacemaker reimplants) should be reviewed using the appropriate medical record (see section 2003.6B) and/or other hospital-supplied relevant clinical information. A reimplant is defined as the actual replacement of the old pacemaker with a new pacemaker. Replacement of electrodes, leads, or generator packs only, does not constitute a reimplant for purposes of this review. (NOTE: Clinical documentation supporting the medical necessity of the implant may be

found in records other than the records of inpatient stay, such as outpatient workups. It is the hospital's responsibility to assure that data about the procedure appears in the inpatient medical record so that the PRO may utilize this information in making its review determination.)

a. Based upon PRO pacemaker review criteria, each case must be reviewed to determine if the procedure was reasonable and necessary for the treatment of the patient's condition. PRO criteria should be based upon physician developed assumptions regarding the clinical goals of pacemaker implantation. The criteria should represent current medical indications for pacemaker implantation.

b. In addition, each case must be reviewed for compliance with the Medicare Coverage Issue Appendix-Chapter II (Section 65-6). Failure to meet the conditions and limitations described in that issuance will result in a denial for which waiver of liability does not apply.

c. Admission review and DRG validation are to be performed on each permanent pacemaker implant and reimplant.

3. Denials.--If the pacemaker implantation is determined not to comply with one or both of the above reviews (2a and 2b) and the implantation was the sole reason for admission (i.e., other reasonable and necessary services were not rendered) the admission should be denied. If the procedure is determined to be not medically necessary or is non-covered but other reasonable and necessary services (beyond routine care) were provided and the admission is medically necessary, deny the procedure. The PRO is to notify the intermediary so that the DRG can be reassigned excluding the procedure.

B. Other Procedure Review.--

1. The PRO must identify and review all other invasive procedures where patterns of abuse have been previously identified. This review includes admission review, DRG validation, and review for medical necessity and appropriateness of the procedure.

2. If the procedure is determined to be not medically necessary or is noncovered and the procedure was the sole reason for admission (i.e., other reasonable and necessary services were not rendered), the admission should be denied. If the procedure is determined to be not medically necessary or is noncovered but other reasonable and necessary services (beyond routine care) were provided and the admission is medically necessary, deny the procedure. The PRO is to notify the intermediary so that the DRG can be reassigned excluding the procedure.

Collins

DEPARTMENT OF HEALTH AND HUMAN SERVICES

September 10, 1984

Associate Regional Administrator
Division of Health Standards and Quality

Case Referrals to the Regional Office

Director, Office of Medical Review
Health Standards and Quality Bureau

PSI

For the first three quarters of FY 1984, a total of 341 cases have been referred to the Regional Office (RO) by the Medical Review Entities (MRE) in Region V. The cases are those reviewed under PPS medical review and identified for referral by PSROs and fiscal intermediaries according to PSRO Transmittal No. 107 and Intermediary Manual Transmittal No. 1097. These transmittals require RO referral of the following types of case:

1. Cases reviewed as seven day readmissions where both admissions are necessary, but where the second stay is a result of the beneficiary being prematurely discharged from the first stay.
2. Transfers to other hospitals, exempt units, or swing beds where the care is determined to be covered but the reason for transferring the patient is not apparent or is questionable.
3. Questionable pacemaker insertions or other invasive procedures.

The Transmittal Instructions are quite clear regarding the first category of referrals but not so for the other two. The requirement for referrals of questionable rehabilitation unit transfers, alcohol/drug treatment unit transfers, swing bed transfers and invasive diagnostic and therapeutic procedures is not discussed in the narrative of PSRO Transmittal 107; it is only noted on the report form. The Intermediary Manual does include a general statement to cover all these types of questionable cases, but calls for referral of patterns only of abusive pacemaker or other invasive procedures rather than individual cases.

FILE COPY

OFFICE	SURNAME	DATE	OFFICE	SURNAME	DATE	OFFICE	SURNAME	DATE
PSRO	Collins Ratliff	9/10/84 9/13/84						

DEPARTMENT OF HEALTH AND HUMAN SERVICES

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is significant

Given this background, the number of cases referred in this Region [illegible] significant. The volume is such that we have been unable to review all the cases individually. We have in some instances provided comments to the referring MRE, particularly when the referrals were inadequately developed. In fact, many of the referrals are so poorly documented that we cannot conduct our review satisfactorily. In March, we released an RO bulletin which outlined the type of information we needed to do our review. The bulletin also made clear that we expected MREs to take corrective action when these types of problem cases were identified. A copy of this bulletin is attached. (See Attachment A.)

indivi.

Of the 39 MREs in Region V, only 15 have referred cases to the RO. Of these 15, the Indiana intermediary has submitted the most - a total of 151, of which 142 (94%) were referred as premature discharges. We did analyze the case referrals received in May. Many of the cases were inadequately reviewed and abusive hospital practice patterns could not be verified. A copy of our comments and the Indiana intermediary's response is attached. (See Attachment B.) The intermediary currently is following up on these cases.

As is the case with the Indiana intermediary, most of the 341 case referrals are cases of premature discharge. The following summarizes the types of case referrals:

Total No. of Referrals	**341**
-Premature discharges	295 (86.5%)
-Inappropriate transfers to other hospitals	40 (11.7%)
-Questionable pacemaker insertions or other procedures	5 (1.5%)
-Inappropriate psychiatric unit transfers	1 (.3%)
-Inappropriate rehabilitation unit transfers	0
-Inappropriate alcohol/drug treatment unit transfers	0
-Inappropriate swing bed transfers	0

The 295 cases referred as premature discharges represent two percent of all 14,889 seven day readmissions or about 2.3 percent of the 12,726 cases which were actually reviewed as having related reasons for admission for both the first admission and second one. About three percent of seven day readmissions were denied as medically unnecessary.

Although the overall percentage of these types of problem cases [illegible] not seem significant, the significance of the individual cases cannot be ignored. Two typical case summaries are:

cannot ignore

FILE COPY

OFFICE	SURNAME	DATE	OFFICE	SURNAME	DATE	OFFICE	SURNAME	DATE

☆U.S. GOVERNMENT PRINTING OFFICE 1981-334-927

2/5/84 to 2/10/84

1. First admission 1/31/84 to 2/4/84. Readmission 2/5/84 to 2/10/84. Patient is an 83 year old male admitted with right pleural effusion. Thoracentesis was performed 2/1/84 and approximately 1,000cc of fluid removed. Patient was discharged 2/4/84 despite chest x-ray done that day which "demonstrates a great deal of fluid in the right hemithorax and some basilar fluid in the left hemithorax." Patient was readmitted 2/5/84 with chief complaint of shortness of breath. Diagnosis: pleural effusion and CHF. CHF was treated and a thoracentesis was again performed 2/9/84. Patient was discharged 2/10/84 to be followed in physician's office. Case reviewed by PSRO physician who felt in light of patient's chest x-ray on the day of discharge 2/4/84, discharge was premature.

effusion

2. A 76-year-old female admitted 3/29/84 and discharged 4/16/84. Final diagnosis: gangrene of right big toe. Amputation on right big toe was done 4/2/84. At time of discharge 4/16/84, the suture line was necrotic and appeared there was still an infection going on with increased white blood cell count. Patient re-admitted 4/24/84 and a below knee amputation of right leg was done. PSRO physician reviewer felt the patient was prematurely discharged.

Due to the inadequate information submitted with these referrals, we have been unable to analyze the patterns of early discharge to determine if it usually occurs at the average length of stay for the DRG. This may or may not be the case. What does seem to be a general conclusion is that these cases resulted from inadequate treatment or work-ups in the first admission. When patterns of abuse such as these are found, PSROs and PROs are to develop sanctions.

The 40 inappropriate transfers to other hospitals represent ten percent of the 4,042 transfers reviewed by the MREs. About three percent of these types of transfers were denied as medically unnecessary. Two typical cases of inappropriate transfers referred to the RO are:

1. A patient was admitted to a PPS hospital with cerebrovascular inefficiency with demonstrated seizures, and transferred to another PPS hospital with orders for the patient to be evaluated and medically managed by a neurologist on staff at the second hospital (the patient was not seen by the neurologist until four days after the transfer). Medical record documentation did not reflect the reason for the transfer, and the PSRO Physician Advisor felt all treatment rendered could have been obtained at the first hospital.

2. The patient was admitted through the emergency room with respiratory distress. The patient remained in the hospital for 3 days while a tracheostomy and biopsy were done. The patient was then transferred to another hospital for a laryngectomy. The admission was necessary and appropriate at the acute care level. The transfer was inappropriate since all services and equipment for a laryngectomy were available at the first hospital and no reason was given for the transfer.

with
3 days
then

Although the reason for transfer is not apparent in most cases, it appears that patient or family preference is frequently the reason for many transfers.

The five invasive procedure cases were referred by the Michigan intermediary. The claims were denied. The procedure in all cases was cystoscopy. We are evaluating these cases further along with additional cases referred in July; however, our initial review finds no particular pattern of abuse in one provider.

Our preliminary conclusions based on this review of the referrals are:

1. The problem of premature discharge does exist, but the numbers are low and at this point it is not possible to tell if the problem is related to the reimbursement change. The problem of inappropriate transfer is at a significant level, but again it is not possible to tell if this is a change in hospital practices.

2. MREs need more detailed instruction on referring these types of cases. Some are referred in error, many reflect inadequate review, and most have incomplete information. Uniformity in reporting/referral requirements is called for. Moreover, MREs are not submitting all the cases they should. It seems unlikely no problem cases have been identified at the other MREs. Also, during Region V CPEP reviews of fiscal intermediary performance of medical review, a significant number of premature discharges were identified which were not referred to the RO. This was true even at the Indiana fiscal intermediary. MREs should be encouraged to carry out review more thoroughly to determine if a case requires referral to the RO.

3. MREs should be given more specific direction on the analysis of patterns of abuse and the development of appropriate correction action and/or sanctions. Our review of the referrals does find possible patterns or at least multiple cases of abuse, and we will be requesting the MRE to follow-up. However, we are concerned as to why MREs have not identified these patterns themselves nor taken action. The requirement for referral or reporting of cases to the RO should include an analysis of the hospital/physician practice patterns and the planned corrective action.

4. ROs need direction on reviewing these referrals. It is not clear to what extent these cases should be developed by RO staff.

Copies of all cases referred tothe RO are enclosed. They are gro[illegible] grouped by the referring MRE. These are being forwarded to you as instructed in [illegible] your May 18, 1984 memorandum to the San Francisco RO.

If you have any questions regarding this information, please contact me or Dorothy Collins, PSRO Branch Chief, on FTS 886-3642.

Robert A. Cullen

Attachments

cc: Director, Division of Health Care Cost Containment
BERC
bcc: ORA, DPO, DFO, Cullen, Collins, Reading file
DCollins/jcw: 09/06/84; 09/07/84

North Dakota Health Care Review Inc
Incidence Report to HCFA Region VIII Office

Type of Incidence:

__X__ Cases where both hospital admissions are necessary, but where the second stay is as a result of the beneficiary being prematurely discharged from the first stay.

______ Cases where care is determined to be covered, but the reason for transferring the patient is not apparent or is questionable.

Medicare beneficiary age 80, HIC Number: [redacted] was admitted on 6/13/84 to [redacted] Medicare Provider number [redacted] by physician license number: [redacted] uroligist for the performance of a transurethral Prostatectomy on 6/15/84.

Patient was discharged on 6/22/84 after a 10 day stay. Medical record stated..."dime size blood clots and blood in urine on day of discharge."

Second admission occurred 6/24/84, same hospital and physician, admitting problem "bleeding, nausia, vomiting and weakness. On 6/26/84 returned to surgery for the performancy of cystoscopy and fulguration. Findings showed oozing blood from the prostate with clots in the bladder. Patients also received 5 units of RBC transfusions. Patient was discharged on 6/30/84. Medical record stated..."patient in pain and discharging pink urine on day of discharge."

Third admission occurred on 7/12/84, same hospital and physician, at which time the patient was transferred to physician [redacted] license No. N.D. [redacted] Admitting problem was bleeding and nausia. A culture and sensitivity was performed which grew staph epidermis. Patient was not treated with antibiotics. The patient received two units of RBC's and was discharged on 7/17/84. Medical record state... "patient has urgency and discharging pink urine on morning of discharge."

NDHCRI Reviewer [redacted]
NDHCRI Physician Advisor [redacted]
Date: 9/6/84

PA Comments: The last urine alysi performed for this patient showed 4+ blood. The urine alysis was performed on 6/20/84. Ther were no further urine alysis performed on this patient for subsequent readmissions of 6/24/84 and 7/12/84, and this is in light of the fact that the medical records reviewed document that the patient had red urine with clots.

North Dakota Health Care Review Inc.
Incident Report to HCFA Region VIII Office

Type of Incidence:

______ Cases where both hospital admissions are necessary but where the second stay is a result of the beneficiary being prematurely discharged from the first stay.

__X__ Cases where care is determined to be covered, but the reason for transferring the patient is not apparent or is questionable.

Medicare beneficiary [redacted], age 60, HIC number [redacted]
was admitted on 5-2-84 to [redacted],
Medicare Provider number: [redacted] by physician [redacted]

Admitted to the hospital for treatment of an ischial rectal and bowel anastormosis abscess. Is a diabetic and has metastatic carcinoma of colon with colostomy. Was transferred to a swing bed on 5/2/84. He was not transferred from his initial room as he remained on Wound and Skin Isolation. Sitz baths Tid are ordered as well as a daily antibiotic rectal irrigation. Has a large amount of pain received Bromptons Cocktail prm. He also received IV fluids. Purulent drainage was noted from the wound. Dressing changes were also ordered Tid. Was discharged 5/5/84. This record was referred questioning the appropriateness of the level of care as it was felt by the RS that he was receiving acute care in a skilled care setting. The physician advisors' comments follow: "It appears from reviewing the chart that the patient received the same care as was given in the acute care ward. This patient should have remained at an acute care level."

NDHCRI Reviewer [redacted]
NDHCRI Physician Advisor [redacted]
Date: 9/6/84

North Dakota Health Care Review Inc.
Incident Report to HCFA Region VIII Office

Type of Incidence:

_______ Cases where both hospital admissions are necessary but where the second stay is a result of the beneficiary being prematurely discharged from the first stay.

___X___ Cases where care is determined to be covered, but the reason for transferring the patient is not apparent or is questionable.

Medicare beneficiary , age 73, HIC number: [redacted] was admitted on 5-9-84 to [redacted] [redacted]edicare Provider number: [redacted] by physician , license number N.D. [redacted]

Patient was discharged 5-8-84 from an acute care to swing bed with the principal diagnosis of diabetic, gangrene of foot. During the acute care episode this patient had and arteriogram which showed complete occlusion of the right femoral artery. It appears this patient had gangrenous toes and a total occlusion of the femoral artery and that surgical intervention was indicated. The patient was transferred back to original acute hospital on 5-14-84 for amputation below the knee.

The findings as stated above were known to the physician before transfer to the swing bed. It was stated in the discharge summary from the first acute care admission that the occlusion of the right femoral artery was evident. The physician was contemplating surgery throughout the swing bed admission and then readmitted this patient in four (4) days for a below knee amputation. The patient was maintained on the same medications and regime during the swing bed admission as the primary acute admission. It appears that the patient should have stayed at an acute level of care throughout.

NDHCRI Reviewer [redacted]
NDHCRI Physician Advisor [redacted]
Date: 9/6/84

Reporting Date: 9 / 26 / 84

NDHCRI INCIDENCE REPORT TO REGIONAL OFFICE

Patient Name: ________________ **HIC NO.** [redacted] **Age:** 90

Admit Date: 8 / 30 / 84 **Hosp. Name** [redacted] **PR No.** 35-0049

Physician Name: ________________ **M.D. License No.** [redacted]

Reviewer Numbers: R.S. [redacted] **P.A.** [redacted] **Reviewed:** 9 / 21 / 84

Incidence Type:

___A. Readmission Subsequent to a Pre-mature Discharge
_X_B. Transfer Of a Questionable Nature
___C. Hospital Initiated Denial Not Reported on Monthly List
___D. Inappropriate Hosp. Init. Den. Issued Prior to DRG ALOS

(Narrative description of the problem or discrepancy using as accurate direct language as possible. Use physicians orders and physician advisor notes for quotations where possible.)

This patient was transferred from the [redacted] hospital acute care ward to the [redacted] swing bed unit.

"The patient was acutely ill and expired after one day in the swing bed unit. I have determined that this patient was acutely ill and should have been kept in the acute hospital. [According to the documentation the quality of care is in questions.] I am not able to determine the quality of care he received in the hospital prior to being sent to the swing bed where he died."

Distribution - Type	A B C D
NDHCRI	A B C D
Regional Office	A B C D
Hospital	A B C D
Attending Physician	A B C D
Fiscal Intermediary	D
Patient	D

DEPARTMENT OF HEALTH & HUMAN SERVICES

Office of Inspector General

Memorandum

Date · OCT 23 1984

/s/ Richard P. Kusserow

From Richard P. Kusserow
Inspector General

Subject PIR-84-09--Inappropriate Readmission and Transfer Practices under the Prospective Payment System--ACTION

To

Carolyne K. Davis, Ph.D.
Administrator
Health Care Financing Administration

The purpose of this Priority Inspection Report (PIR) is to alert you to a serious problem encountered during our ongoing review of the implementation of the Prospective Payment System (PPS).

I expressed my concern, as early as July 1983, that the Medicare program and its beneficiaries were vulnerable to abuse through medically inappropriate discharges, transfers, and readmissions by hospitals under PPS. The Health Care Financing Administration (HCFA) provided assurances during the preparation of the PPS regulations that this problem would be handled by Medical Review Entities (MREs) through the review of 100 percent of all readmissions and transfers and the denial of payment where appropriate.

We find that evidence is mounting to suggest abuse of the PPS is occurring through the premature discharge and subsequent readmission of patients in need of inpatient care, and the inappropriate transfer of patients from PPS hospitals to other hospitals or units. As of July 31, 1984, 1130 of these cases have been identified by MREs across the country. Additionally, our analysis of data from Health Standards and Quality Bureau (HSQB) Regional Offices and MREs indicates that the actual number of cases may be significantly greater.

The Health Care Financing Administration has the authority to deny payment or require corrective action on a case by case basis, of medically inappropriate admissions, readmissions, transfers or other inappropriate practices under the PPS system (42 CFR 405.472(e)(1). We have confirmed this with

OGC (Inspector General Division). Yet, it appears that HCFA may not be taking action when encountering these problems. Further, when it appears that a hospital is engaged in a pattern of inappropriate admissions, that case should be referred to the OIG for potential termination of the provider agreement under section 1866(b) of the Act (42 CFR section 405.472(e)(3)).

It appears that HSQB has issued instructions which are not in conformance with the OGC opinion. Therefore, the MREs, following present HSQB insructions, are not required to take corrective action on a case by case basis. We recommend that HCFA ensure corrective action is being taken by clarifying its instructions for the MREs. To avoid possible adverse patient outcomes, the following actions should be taken immediately:

1. Require hospitals to take the necessary action to prevent or correct the inappropriate practices. Nonconforming hospitals should be notified that continued abuse will lead to a sanction recommendation.

2. Deny payment under the authority of 42 CFR 405.472(e)(1);

   a. any case involving the unnecessary admission of an individual;

   b. any case involving a medically necessary readmission which the MRE determines resulted from a premature discharge;

   c. any case involving a transfer when the MRE determined that the transfer was inappropriate; or

   d. any other inappropriate medical or other practice identified.

3. Include denials made under 42 CFR 405.472(e)(1) on the monthly report of medical review activity.

4. Develop a sanction recommendation when a pattern of abuse is identified, pursuant to 42 CFR 405.472(E)(3).

Although the 1130 cases encountered to date might represent as much as $3.2 million of inappropriate payments (based on average DRG payment of $2,820), our major concern relates to potential patient abuses.

The impact of this type of abuse on quality is so significant that its potential visibility could jeopardize the integrity of the medical review process and the payment system. Therefore, I would appreciate receiving your views on these recommendations and feedback on any action that you plan to take at the earliest possible date. We would be pleased to meet with you to discuss this matter further if you so desire.

The attached report, which details our findings and summarizes several actual cases, is provided for your staff's review. If you or your staff have any questions pertaining to this report, please contact Barton McCann, M.D. of OHFI who may be reached on (FTS) 987-0831.

Attachment

Attachment 1

DEPARTMENT OF HEALTH & HUMAN SERVICES

Office of the Secretary

Memorandum

Date OCT 3 1984

From D. McCarty Thornton
Supervisory Trial Attorney
Office of General Counsel/Inspector General Division

Subject HCFA's Authority to Deny Payment for Individual Instances of Medically Inappropriate Care under The Prospective Payment System.

To Richard P. Kusserow
Inspector General

At the last Health Care Coordinating Committee meeting, we discussed the increasing evidence of medically inappropriate discharges, transfers and readmissions by hospitals under the prospective payment system. The legal question was raised whether HCFA was the authority to deny payment for individual instances of such behavior, or whether HCFA is obligated to demonstrate a pattern of such behavior or fraudulent intent on the part of the hospital, prior to denying payment for any individual instances.

We have concluded that under the PPS regulations, HCFA clearly does have the authority to deny payment in individual instances of inappropriate medical services under PPS, without any additional showing as to "pattern" or intent of the hospital to circumvent the PPS system. THe regulations provide as follows:

> (1) Denial of payment as a result of admissions and quality review.
>
> (1) If HCFA determines, based upon information supplied by a medial review agent, that a hospital has misrepresented admissions, discharge, or billing information, or has taken an action that results in the unnecessary admission of an individual entitled to benefits under Part A, unnecessary multiple admissions of an individual, or other inappropriate medical or other practices with respect to beneficiaries or billing for services furnished to beneficiaries, HCFA may as appropriate --
>
> (i) Deny payment (in whole or in part) under Part A with respect to inpatient hospital services provided with respect to such an unnecessary admission or subsequent readmission of an individual; or

> (ii) Require the hospital to take other corrective action necessary to prevent or correct the inappropriate practice.

42 C.F.R. § 405.472(e)(1). 48 Fed. Reg. 39821 (Sept. 1, 1983) (emphasis supplied). As a separate remedy, HCFA's regulations provide that where HCFA finds evidence of a "pattern of inappropriate admission and billing practices that have the effect of circumventing" the PPS system, that case will be referred to OIG for consideration of termination of the provider agreement. 42 C.F.R. § 405.472(e)(3). 49 Fed. Reg. 318 (Jan. 3, 1984).

The Social Security Act contains several provisions which are relevant to the issues discussed above. Section 1886(f)(2) provides authority for HCFA to deny payment and require corrective action where a hospital has engaged in an instance of unnecessary admission or multiple unnecessary admissions, but the hospital must have acted "in order to circumvent" the PPS method. This latter requirement seemingly would necessitate proof of intent on the hospital's part. However, the above quoted regulatory provisions are expressly not based on § 1886(f)(2), but rather on §§ 1102, 1862(d) and 1876. (See: 48 Fed. Reg. 39789). These statutory provisions, along with §§ 1154(a) and 1866(a), provide a sufficient statutory basis for HCFA's regulations as drafted.

Please be advised that the substance of this opinion was discussed with representatives of Office of General Counsel, HCF/HDS Division, and that they concur.

cc: Edward Steinhouse
OGC/HCF/HDS

Attachment 2

Priority Inspection Report - Inappropriate Readmissions
and Transfers Under the Prospective Payment System
OHPI Control No. 84-09

Introduction

The Office of Inspector General recently conducted an assessment of the Medicare Prospective Payment System (PPS) for inpatient services. We have identified a serious problem concerning the medical review of readmissions and transfers.

Current instructions to the MREs (Appendix A) direct them to deny payment for medically unnecessary readmissions and transfers in accordance with section 1862(a)(1) or (9) of the Social Security Act (Appendix B). However, if the care is determined to be covered but the readmission resulted from premature discharge or the reason for transfer was not apparent, the MREs are not directed to deny payment. Rather, they are directed to refer the cases to the appropriate Health Standards and Quality Bureau (HSQB) regional office. We believe that the regulations at 42 CFR 405.472(e)(1) (Appendix C) give HCFA the authority to deny payments and that failure to exercise that authority could involve as much as $3.2 million in inappropriate payments. Of greater concern, is that hospitals are not being notified that corrective action is required to prevent or correct the inappropriate readmission or tranfer practice. The failure to make this point clear subjects other beneficiaries to potential poor quality care and leads to unnecessary delays in the sanction process whereby a provider who has demonstrated a pattern of inappropriate practices may be excluded from participation in the Medicare program.

Discussion

While PPS introduces much needed incentives for cost control in hospitals, it also has negative implications which result from the incentive to reduce costs per case. This incentive may lead to problems associated with readmissions following premature discharges, including adverse patient outcomes and additional DRG payments for the continued treatment of the same medical condition.

The incentive to reduce cost per case also encourages the transfer of patients from PPS hospitals to other PPS hospitals or to PPS exempt hospitals and units. This practice also may lead to adverse patient outcomes in that patients may be subjected to unnecessary risks during the transfer process and, once transferred, may not receive the proper level of care. As a result of the current PPS transfer policy, when this occurs, additional payments are made depending on whether the transfer was to another PPS hospital or to an exempt hospital or unit.

The Legislative History of the Social Security Amendments of 1983, P.L. 98-21, (Appendix D) clearly indicates that the Congress recognized these potentially negative incentives and intended the Secretary to deny payment for such admissions or to require the hospital to take corrective action.

It was the understanding of the OIG that the mandated 100 percent review of all transfers and readmissions (within 7 days of discharge), which HSQB requires of MREs, was intended to identify unnecessary admissions, readmissions, and questionable transfers and was intended to result in denial of payment or corrective action. We have learned, however, that no such action is taking place and that the cases are simply being referred from the MREs to the HSQB regional offices. According to the August 15 "Report on PPS Monitoring Activities" from HCFA's PPS Monitoring

Committee, a cumulative total of 23,293 transfers have been reviewed and 898 denied. In addition, 58, 831 readmissions have been reported with 45, 484 reviewed and 1579 denied. These denials are being made in accordance with section 1862(a)(1) or (9) of the Act and are based on determinations of reasonableness and medical necessity. The report does not include cases which the MREs have reviewed and referred to HSQB regional offices. However, the data is being collected and, as of July 31, 717 readmission cases and 413 transfer cases have been referred. Based on an average DRG payment of $2820, these 1130 cases could involve as much as $3.2 million.

In meetings with HSQB we learned that the authority to deny payment or require corrective action is not being exercised. We were informed that the reason for this stems from their opinion that individual cases of inappropriate readmissions and transfers may not be denied. They believe that action may be taken only when it has been determined that the hospital has engaged in a pattern of inappropriate readmissions and transfers.

We disagree with that position and have been advised by the Office of General Counsel that the regulations at 42 CFR 405.472(e)(1) (Appendix C) indicate that action may be taken on individual cases.

We have reviewed a small sample of cases and have determined that HCFA must take immediate corrective action to exercise its authority. Our review confirms that the potentially negative impact of PPS on quality is occurring and that providers are taking actions to circumvent the intent of the payment system. The following is a brief summary of several of these cases:

1. Patient G.R. 86 year old male
   - Admitted to hospital 12/31/83 for unstable angina, congestive heart failure, chronic renal failure.
   - Transferred to exempt rehabilitation (rehab) unit of the same hospital 1/31/84 although the rehab physician described him as "extremely unstable."
   - Readmitted to the hospital from the rehab unit after 4 days when he developed septicemia.
   - Transferred back to rehab unit 2/16/84 for 12 days.
   - Readmitted to hospital 2/28/84 because of progressive renal and heart failure.
   - Expired 3/8/84.
   - This case resulted in 3 DRG payments and 2 payments under cost reimbursement methods.

2. Patient J.H. 70 year old male
   - Admitted to rehab unit 2/6/84 after a stroke.
   - Transferred on 2/26/84 to intensive care unit of the same hospital after an acute right iliofemoral arterial occlusion with impending gangrene. Stayed in ICU for 1 day. The patient's family refused to give permission for surgery.
   - Transferred back to rehab unit on 2/26/84 with temperature 102.4°, CVP line in place, on antibotics and heparin.
   - Expired in rehab unit 2/28/84.
   - This resulted in 1 DRG payment and 1 payment under cost reimbursement methods. The second rehab admission was questioned for failure to meet coverage requirements.

3. Patient D.S. 69 year old female

   - Admitted 2/19/84 with influenza. Discharged 2/22/84.
   - Readmitted 2/27/84. Attending physician note states she was readmitted "having left before she was really well enough to go home."
   - This resulted in 2 DRG payments.

4. Patient A.W. 71 year old male

   - Admitted 2/11/84 for transuretheral bladder tumor resection.
   - Discharged 2/14/84. Had not had bowel movement after surgery.
   - Readmitted same day with abdominal pain secondary to constipation.
   - This resulted in 2 DRG payments.

5. Patient C.M. 95 year old male

   - Admitted 12/8/83 with back pain secondary to a fall. Noted to have a urinary tract infection (UTI).
   - Discharged 12/11/83 on oral antibiotics.
   - Readmitted 12/13/83 for "definitive treatment of UTI."
   - Discharged 12/16/83.
   - This resulted in 2 DRG payments.

Conclusions

- Abuse of the PPS is occurring through the premature discharge and subsequent readmission of patients in need of inpatient medical care and the inappropriate transfer of patients from PPS hospitals to other PPS hospitals or to exempt hospitals and/or units.
- We believe that the authority to deny payment for these practices is not being exercised as a result of the view of the HSQB that individual cases may not be denied.
- Based on the opinion of the of the Office of General Counsel, we believe the authority exists for HCFA to deny payment or require corrective action on a case by case basis.

Recommendations

We recommend that HCFA immediately direct the MREs to take the following actions in regard to inappropriate readmissions and transfers:

1. Deny payment under the authority of 42 CFR 405.472(e)(1):

    a) any case involving the unnecessary admission of an individual;

    b) any case involving a medically neceassary readmission which the MRE determines resulted from a premature discharge;

    c) any case involving a transfer when the MRE determines that the transfer was inappropriate; or

    d) any other inappropriate medical or other practice identified.

2. Require the hospital to take the necessary action to prevent or correct the inappropriate practices. The hospital should also be notified that continued abuse may lead to a sanction recommendation.

3 Include denials made under 42 CFR 405.472(e)(1) on the monthly report of medical review activity.

4. Develop a sanction recommendation when a pattern of abuse is identified, pursuant to 42 CFR 405.472(E)(3).

Appendix A

B. Transfers

Identify all cases involving transfers to exempt distinct psychiatric, rehabilitation, and alcohol/drug treatment units and swing bed reimbursement in acute facilities. These cases are to be identified because the transfer constitutes a "discharge" and "admission", thereby triggering a second payment opportunity. When the date of admission for the second case is the same as the date of discharge for the first case, the second case is subject to medical review to determine whether the second admission was medically necessary and appropriate.

Exempt distinct units of acute hospitals are those which have been assigned separate provider numbers. These units can be identified by the following alpha codes in the third position of the provider number:

S - exempt distinct psychiatric units;
T - exempt distinct rehabilitation units;
U - exempt swing beds; and
V - exempt alcohol/drug treatment units.

The regional office will notify the PSRO of those units which are exempt from PPS.

1. Identify all cases involving transfers to psychiatric units which are distinct parts of acute hospitals and which have been determined to be exempt from the PPS.

   a. Identify cases containing an ICD-9-CM psychiatric code other than those listed below and, using appropriate medical records, manually review every 10th case (selected randomly) for each hospital.

   2900 29010 2911 2913

   2939 2949 30000 30390

   30391 30392 30393 3109

   317 3180 3181 3182

   319 V6289

   b. For cases showing the diagnostic codes listed above, review every case using appropriate medical records. Cases with these codes are to be reviewed as these codes are generally reflective of organic brain processes rather than psychiatric diagnoses.

c. Identify all cases that do not show a valid ICD-9-CM psychiatric code. Request appropriate medical records and review every case.

d. Make a determination about the medical necessity and appropriateness of the admission. The admission must be in compliance with Section 1862 (a)(1) or (9) of the Act. If it is determined that the care is noncovered and denied, make a recommendation regarding the application of the waiver of liability provision (Section 1879 of the Act) to the intermediary.

(1) The case must show that the principal diagnosis is psychiatric in nature and that the patient is receiving "active psychiatric treatment".

(2) Report quarterly to the regional office any questionable cases, where a denial cannot be made but the reason for the transfer is questionable. Summarize the problem including specifics as to how often the problem has been identified.

e. If, over a calendar quarter, a significant pattern of unnecessary transfers to exempt psychiatric units is identified, increase the review for the next quarter to 100% of psychiatric transfers. A "significant pattern" occurs when 2.5% of the sampled transfers to a psychiatric unit of an acute hospital or three cases (whichever is greater) are found to be unnecessary. As an alternative, identify all subcategories which have a 2.5% or three case error level (whichever is greater). The review of all such subcategories can then be substituted for 100% review. If, in subsequent quarters, the number of unnecessary or inappropriate admissions to exempt psychiatric units of that acute hospital as compared to the total number of such admissions to exempt psychiatric units of that hospital is less than 2.5% or three cases, review as outlined in Section I. B. 1. a.

2. Identify all cases involving transfers to rehabilitation units which are distinct parts of acute hospitals and which have been determined to be exempt from the PPS.

Using the appropriate medical records, review each case and make a determination on the medical necessity and appropriateness of the admission (i.e., whether or not to deny the admission consistent with Section 1862(a)(1) or (9) of the Act). If it is determined that the care is noncovered and denied, make a recommendation regarding the application of the waiver of liability provision (Section 1879 of the Act) to the intermediary.

3. Identify all cases involving transfers to alcohol/drug treatment units which are distinct parts of acute hospitals and which have been determined to be exempt from the PPS.

   a. Request appropriate records.

   b. Review every case and make a determination about the medical necessity and appropriateness of change in payment status (i.e., whether or not to deny consistent with the Section 1862(a)(1) or (9) of the Act.) If it is determined that the care is noncovered and denied, make a recommendation regarding the application of the waiver of liability provision (Section 1879 of the Act) to the intermediary.

4. Identify all cases involving transfers to swing bed reimbursement of acute hospitals, which are exempt from the PPS.

   a. Request appropriate records.

   b. Review every case and make a determination about the medical necessity and appropriateness of change in payment status (i.e., whether or not to deny consistent with the Section 1862(a)(1) or (9) of the Act.) If it is determined that the care is noncovered and denied, make a recommendation regarding the application of the waiver of liability provision (Section 1879 of the Act) to the intermediary.

If a pattern of excessive numbers of unnecessary transfers to psychiatric, rehabilitation, or alcohol/drug treatment units or changes to swing bed reimbursement is identified, develop a sanction recommendation.

C. Transfer from a PPS Hospital to any other Hospital.

Identify all cases involving transfers from a PPS hospital to any other (PPS or non-PPS) acute hospital. Most cases can be identified retrospectively through the PSRO's data system. Since the hospital is required to ask the patient or his/her family if (s)he has been in an institution in the last 60 days, the hospital will notify the PSRO of such transfers, if the PSRO data system is unable to identify such transfer cases. (When a beneficiary is transferred from a prospective payment hospital to any other PPS hospital, do not consider this a discharge from the transferring hospital.)

1. Using the appropriate medical records, make a determination as to medical necessity and appropriateness of the admission to the receiving hospital (i.e., whether or not to deny the admission consistent with Section 1862 (a)(1) or (9) of the Act). In addition, validate the diagnostic and procedural information if the receiving hospital is under PPS.

2. If it is determined that care is noncovered and denied, make a recommendation regarding the application of the waiver of liability provision (Section 1879 of the Act) to the intermediary.

3. Refer to the regional office any cases where care is determined to be covered but the reason for transferring the patient is not apparent or is questionable. Include specifics of how often this problem (or potential) problem has been identified.

D. Admissions within Seven Calendar Days of Discharge from an Acute Facility

Identify all cases involving subsequent admissions to any acute hospital (i.e., PPS or non-PPS) within 7 calendar days of discharge from a PPS acute care facility. (Do not count the day of discharge, nor the day of admission. For example, the 7-day provision would be in effect when the patient is discharged from the hospital on June 1 and (re)admitted on June 9.)

Most cases can be identified retrospectively through the PSRO data system. Since the hospital is required to ask the patient or his/her family if (s)he has been in an institution in the last 60 days, the hospital will notify the PSRO, if the PSRO data system is unable to identify such cases.

1. Review the case for the previous admission in conjunction with the questioned case if the two hospitals are in the same PSRO area. If the two hospitals are not in the same PSRO area, do not review further unless the case is questionable or is under review for other reasons.

2. If diagnostic data supports a decision that the two confinements are not related (e.g., one is for a fractured femur, and the other is for a cholecystectomy), no further review is necessary.

3. If the two confinements could possibly be related, review every case using appropriate medical records to determine if the patient was prematurely discharged from the prior confinement,

thus causing the repeat admission. Perform analysis relevant to stay at first hospital to determine cause(s) and breadth of problem(s).

4. Where an admission was found not to be necessary or appropriate, deny the case and make a recommendation regarding the application of the waiver of liability provision (Section 1879 of the Act) to the intermediary.

5. If the number of unnecessary admissions to a hospital within 7 calendar days of discharge from a PPS hospital divided by the total admissions within seven calendar days of discharge from a PPS hospital reviewed from that hospital is 2.5% or three cases (whichever is greater), review every such case in the following quarter, including those where the 2 stays involve hospitals which are not in the same PSRO area.

6. Institute quality review studies where a problem (e.g., premature discharge) is identified. (See Transmittal Number 100.)

7. Report to the regional office any cases where both admissions are necessary, but where the second stay is as a result of the beneficiary being prematurely discharged from the first stay, summarizing findings. When a pattern of such abuse is identified, develop a sanction recommendation.

II. Invasive Diagnostic and Therapeutic Procedure Review

The performance of invasive diagnostic and therapeutic procedures may affect DRG classifications thus leading to increased reimbursement. Therefore, review all areas involving invasive diagnostic or therapeutic procedures where PSRO data has identified a substantial problem.

A. Review every case involving permanent pacemaker insertion using appropriate medical records.

1. When the procedure is found not to meet the PSRO criteria, the physician reviewer/advisor will determine if the procedure was unnecessary. If the procedure is/was found to be unnecessary, deny the procedure and notify the affected parties.

2. If the review is retrospective (i.e., after the pacemaker has been inserted), notify the intermediary so that the DRG can be (re)calculated excluding the procedure.

Appendix B

medical care to the individual at the time the individual makes an election to receive hospice care.

(4)(A) An entity which is certified as a provider of services other than a hospice program shall be considered, for purposes of certification as a hospice program, to have met any requirements under paragraph (2) which are also the same requirements for certification as such other type of provider. The Secretary shall coordinate surveys for determining certification under this title so as to provide, to the extent feasible, for simultaneous surveys of an entity which seeks to be certified as a hospice program and as a provider of services of another type.

(B) Any entity which is certified as a hospice program and as a provider of another type shall have separate provider agreements under section 1866 and shall file separate cost reports with respect to costs incurred in providing hospice care and in providing other services and items under this title.

EXCLUSIONS FROM COVERAGE

SEC. 1862. [42 U.S.C. 1395y] (a) Notwithstanding any other provision of this title, no payment may be made under part A or part B for any expenses incurred for items or services—

(1)(A) which, except for items and services described in subparagraph (B), (C), or (D)[1], are not reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member,

(B) in the case of items and services described in section 1861(s)(10), which are not reasonable and necessary for the prevention of illness,

(C) in the case of hospice care, which are not reasonable and necessary for the palliation or management of terminal illness,[2] and

(D) in the case of clinical care items and services provided with the concurrence of the Secretary and with respect to research and experimentation conducted by, or under contract with, the Prospective Payment Assessment Commission or the Secretary, which are not reasonable and necessary to carry out the purposes of section 1886(e)(6);[3]

(2) for which the individual furnished such items or services has no legal obligation to pay, and which no other person (by reason of such individual's membership in a prepayment plan or otherwise) has a legal obligation to provide or pay for;

(3) which are paid for directly or indirectly by a governmental entity (other than under this Act and other than under a health benefits or insurance plan established for employees of such an entity), except in the case of rural health clinic services, as defined in section 1861(aa)(1), and in such other cases as the Secretary may specify;

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[1] P.L. 98-21, §601(f)(1), struck out "(B) or (C)" and substituted "(B), (C), or (D)", effective with respect to items and services furnished by or under arrangements with a hospital beginning with its first cost reporting period that begins on or after October 1, 1953.

[2] P.L. 97-248, §122(f)(1), amended paragraph (1) in its entirety. For the effective date, see P.L. 97-248, "Tax Equity and Fiscal Responsibility Act of 1982", §122(h)(1), p. 791.

[3] P.L. 98-21, §601(f)(4), added subparagraph (D), effective with respect to items and services furnished by or under arrangements with a hospital beginning with its first cost reporting period that begins on or after October 1, 1983.

(4) which are not provided within the United States (except for inpatient hospital services furnished outside the United States under the conditions described in section 1814(f) and, subject to such conditions, limitations, and requirements as are provided under or pursuant to this title, physicians' services and ambulance services furnished an individual in conjunction with such inpatient hospital services but only for the period during which such inpatient hospital services were furnished);

(5) which are required as a result of war, or of an act of war, occurring after the effective date of such individual's current coverage under such part;

(6) which constitute personal comfort items (except, in the case of hospice care, as is otherwise permitted under paragraph (1)(C))[1];

(7) where such expenses are for routine physical checkups, eyeglasses or eye examinations for the purpose of prescribing, fitting, or changing eyeglasses, procedures performed (during the course of any eye examination) to determine the refractive state of the eyes, hearing aids or examinations therefor, or immunizations (except as otherwise allowed under section 1861(s)(10) and paragraph (1)(B)[2])[3];

(8) where such expenses are for orthopedic shoes or other supportive devices for the feet;

(9) where such expenses are for custodial care (except, in the case of hospice care, as is otherwise permitted under paragraph (1)(C))[4];

(10) where such expenses are for cosmetic surgery or are incurred in connection therewith, except as required for the prompt repair of accidental injury or for improvement of the functioning of a malformed body member;

(11) where such expenses constitute charges imposed by immediate relatives of such individual or members of his household;

(12) where such expenses are for services in connection with the care, treatment, filling, removal, or replacement of teeth or structures directly supporting teeth, except that payment may be made under part A in the case of inpatient hospital services in connection with the provision of such dental services if the individual, because of his underlying medical condition and clinical status or because of the severity of the dental procedure,[5],[6] requires hospitalization in connection with the provision of such services;

(13) where such expenses are for—

(A) the treatment of flat foot conditions and the prescription of supportive devices therefor,

(B) the treatment of subluxations of the foot, or

---

[1] P.L. 97-248, §122(f)(2), inserted "(except, in the case of hospice care, as is otherwise permitted under paragraph (1)(C))". For the effective date, see P.L. 97-248, "Tax Equity and Fiscal Responsibility Act of 1982", §122(h)(1), p. 791.

[2] P.L. 97-248, §122(f)(3), inserted "(B)". For the effective date, see P.L. 97-248, "Tax Equity and Fiscal Responsibility Act of 1982", §122(h)(1), p. 791.

[3] P.L. 96-611, §1(a)(3)(B), inserted "(except as otherwise allowed under section 1861(s)(10) and paragraph (1))", effective on, and applicable to services furnished on or after, July 1, 1981.

[4] P.L. 97-248, §122(f)(4), inserted "(except, in the case of hospice care, as is otherwise permitted under paragraph (1)(C))". For the effective date, see P.L. 97-248, "Tax Equity and Fiscal Responsibility Act of 1982", §122(h)(1), p. 791.

[5] P.L. 96-499, §936(c), inserted "or because of the severity of the dental procedure,", effective with respect to services provided on or after July 1, 1981.

[6] As in original. One comma should be stricken.

- Appendix C

and coinsurance), does not exceed the total amount which would have been paid (before application of deductible and coinsurance) if all the services had been viewed as covered.); and

(v) The customary charge differential for a private room or other luxury service that is more expensive than is medically required and is furnished for the personal comfort of the beneficiary at his or her request (or that of the person acting on his or her behalf).

(2) *Prohibited charges.* A hospital may not charge a beneficiary for any services for which payment is made by Medicare, even if the hospital's costs of furnishing services to that beneficiary are greater than the amount the hospital is paid under the prospective payment system.

(c) *Admissions and quality review.* Beginning on October 1, 1984 a hospital must have an agreement with a Utilization and Quality Control Peer Review Organization (PRO) to have its admission patterns, transfers, days or services furnished in outlier cases, the validity of diagnostic information, and the quality of its services reviewed on an on-going bases.

(d) *Medical review activities for hospitals paid under the prospective payment system*—(1) *Admission pattern monitoring (APM).* HCPA will prepare a report which compares a hospital's discharge rate for a quarter with the same hospital's discharge rate for the previous eight quarters. If the hospital's discharge rate increases significantly, the report will be sent to the medical review agent for analysis.

(i) The medical review agent, during the course of its analysis, may request information or records from the hospital, and may conduct on-site medical record review to determine if the increased discharges reflected medically necessary and appropriate admissions.

(ii) If, as a result of analysis under paragraph (d)(1)(i) of this section, the medical review agent finds a pattern of unnecessary or inappropriate admissions, the medical review agent will intensify medical review activities.

(2) *DRG validation.* (i) The attending physician must, shortly before, at or shortly after discharge (but before a claim is submitted), attest to in writing the principal diagnosis, secondary diagnoses, and names of procedures performed.

(ii) The medical review agent will review, every quarter, at the hospital, a random sample of discharges for the previous quarter, to verify that the diagnostic and procedural coding, used by the hospital for DRG assignment, is substantiated by the corresponding medical records.

(iii) If the diagnostic and procedural information, attested to by the attending physician, is found to be inconsistent with the hospital's coding or DRG assignment, the hospitals' coding will be appropriately changed and payments recalculated, based on the appropriate DRG assignments.

(iv) If the information attested to b the physician as stipulated under paragraph (d)(2)(i) of this section is found not to be correct, the medical review agent will change the coding and assign the appropriate DRG, based upon the changed coding.

(e) *Denial of payment as a result of admissions and quality review.* (1) I HCPA determines, based upon information supplied by a medical review agent, that a hospital has misrepresented admissions, discharge, or billing information, or has taken an action that results in the unnecessary admission of an individual entitled to benefits under Part A, unnecessary multiple admissions of an individual, o other inappropriate medical or othe practices with respect to beneficiarie or billing for services furnished t beneficiaries, HCPA may as appropri ate—

(i) Deny payment (in whole or i part) under Part A with respect to in patient hospital services provided wit respect to such an unnecessary admis sion or subsequent readmission of a individual; or

(ii) Require the hospital to tak other corrective action necessary t prevent or correct the inappropriat practice.

(2) When payment with respect t admission of an individual patient i denied under paragraph (e)(1)(i) o this section, and liability is not waive in accordance with §§ 405.330 t 405.332—

Append: C

(i) If the medical review agent is a PRO, notice and appeals will be provided under procedures established by HCPA to implement the provisions of sections 1155 of the Act, Right to Hearing and Judicial Review.

(ii) If the medical review agent is a PSRO, assuming review in accordance with § 463.26(c)(1), notice and appeals will be provided in accordance with regulations in Part 473 of this chapter, Hearings and Appeals on PSRO determinations.

(iii) If, in the absence of a PRO or PSRO, a fiscal intermediary acts as a medical review agent, notice and appeals will be provided in accordance with regulations in Subpart G of this part, Reconsiderations and Appeals under the Hospital Insurance Program.

(3) A determination made by HCPA under paragraph (e)(1) of this section, related to a pattern of inappropriate admissions and billing practices that have the effect of circumventing the prospective payment system, shall be effective at such time and upon such reasonable notice to the public and to the person furnishing the services involved as specified in Part 420 of this chapter. Such determination shall be effective in the manner provided in section 1866(b) (3) and (4) of the Act, and regulations in Part 489 of this chapter, with respect to terminations of agreements, and shall remain in effect until HCPA finds and gives reasonable notice to the public that the basis for such determination has been removed and that there is reasonable assurance that it will not recur.

(4) Any person furnishing services described in paragraph (e)(1) of this section who is dissatisfied with a determination made by HCPA under paragraph (e)(3) shall be entitled to reasonable notice and opportunity for a hearing thereon by HCPA to the same extent as is provided in section 205(b) of the Act and to judicial review of the final decision after such hearing as is provided in section 205(g).

(5) HCPA will promptly notify each State agency which administers or supervises the administration of a State plan approved under title XIX of the Act of any determination made under the provisions of paragraph (e)(3) of this section.

(f) *All inpatient hospital services furnished either directly or under arrangements.* The applicable payments made under the prospective payment system, as described in § 405.477, are payment in full for all inpatient hospital services, as defined in § 409.10, other than physicians' services to individual patients reimbursable on a reasonable charge basis (in accordance with the criteria of § 405.550(b)). Except as provided in § 489.23 of this chapter, HCPA will not pay any provider or supplier other than the hospital for services furnished to a beneficiary who is an inpatient, except for physicians' services reimbursable under § 405.550(b). The hospital must furnish all necessary covered services to the beneficiary either directly or under arrangements (as defined in § 409.3).

(g) *Reporting and recordkeeping requirements.* All hospitals participating in the prospective payment system under this section must meet the recordkeeping and cost reporting requirements of §§ 405.406 and 405.453.

[48 FR 39817, Sept. 1, 1983; 48 FR 48468, Oct. 19, 1983]

§ 405.473 Basic methodology for determining Federal prospective payment rates.

(a) *DRG classification and weighting factors*—(1) *Diagnosis-related groups.* HCPA will establish a classification of inpatient hospital discharges by Diagnosis-Related Groups (DRGs).

(2) *DRG weighting factors.* HCPA will assign an appropriate weighting factor for each DRG that reflects the estimated relative cost of hospital resources used with respect to discharges classified within that group compared to discharges classified within other groups.

(3) *Assignment of Discharges to DRGs.* HCPA will establish a methodology for classifying specific hospital discharges within DRGs that ensures that each hospital discharge is appropriately assigned to a single DRG based on essential data abstracted from the inpatient bill for that discharge.

to estimate national effects. Michigan accounts for about 15 percent of GA expenditures nationwide.

7. Estimate comparison: None.

8. Previous CBO estimate: None.

9. Estimate prepared by: Stephen Chaikind, Malcolm Curtis, Richard Hendrix, John Navratil, Janice Peskin, Roger Hitchner, Kathleen Shepherd (226-2820), James Nason (226-2689).

10. Estimate approved by:

C. G. NUCKOLS

(For James L. Blum, Assistant Director for Budget Analysis).

VOTE OF THE COMMITTEE

In compliance with paragraph 7(c) of Rule XXVI of the Standing Rules of the Senate, the following statement is made relative to the vote by the committee on the motion to report the bill S. 1, as amended, was ordered favorably reported by a vote of 18 yeas, 1 nay.

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REGULATORY IMPACT STATEMENT

Because of the urgent nature of this legislation and the necessity for prompt action to assure the financial solvency of the social security program, it is necessary to dispense with the requirements of paragraph 12 of Rule XXVI of the Standing Rules of the Senate relating to regulatory impact statements as is provided for in the last sentence of such paragraph.

* * * * *

HOUSE REPORT NO. 98-25, PART 1

The Committee on Ways and Means to whom was referred the bill (H.R. 1900) to assure the solvency of the Social Security Trust Funds, to reform the medicare reimbursement of hospitals, to extend the Federal supplemental compensation program, and for other purposes, having considered the same, report favorably thereon without amendment and recommend that the bill do pass.

I. PURPOSE AND SCOPE

The Social Security Act Amendments of 1983 include amendments to the social security, medicare, supplemental security income and unemployment compensation programs. The primary focus of your Committee's bill is on restoring the financial soundness of the old age and survivors' insurance (OASI) program, which is facing severe cash shortfalls over the next 7 years. The Congress took major steps in 1977 to address the financing crisis facing the social security system at that time, and to reduce the long-term deficit projected for the next century. However, the performance of the economy during the period since 1977 has resulted in an even more severe short-term financing shortfall for the OASI program

[page 143]

Your Committee's bill would provide for the same procedures for administrative and judicial review of payments under the prospective system as is currently provided for cost-based payments. In general, the same conditions, which now apply for review by the PRRB and the courts, would continue to apply.

With respect to administrative and judicial review, your Committee's bill would permit review except in the narrow cases necessary to maintain budget neutrality and avoid adversely affecting the establishment of the diagnosis related groups, the methodology for the classification of discharges within such groups, and the appropriate weighting of such groups.

It is the purpose of your Committee's bill to establish a prospective payment system for medicare. The prospective payment will no longer have any relationship to a hospital's actual costs. Thus, it is your Committee's intent that a hospital would not be permitted to argue that the level of the payment which it receives under the system is inadequate to cover its costs.

The Secretary would be required by your Committee's bill to establish payment amounts in fiscal 1984 and 1985 at a level which will cause the system to be budget neutral in relation to current law. Of necessity, this limitation will require the Secretary, after taking into account adjustment required under the system, to change the basic payment rate to a level which will result in budget neutrality. For example, the Secretary might set the rate at 102 percent rather than 105 percent of the mean. The altering of this basic payment rate to achieve budget neutrality is not reviewable.

Your Committee bill precludes review of the establishment, methodology and weighting of diagnosis related groups because of the complexity of such action and the necessity of maintaining a workable payment system. Thus, neither the definition of the different diagnosis related groups, their weights in relation to each other, nor the method used to assign discharges to one of the groups would be reviewable. Whether there was an error in human judgment in coding an individual patient's case would be reviewable.

7. ADMISSIONS AND QUALITY REVIEW

The Secretary would be required to establish a system for monitoring admissions and discharges of both hospitals receiving prospective payment and of hospitals exempt from prospective payment but continuing to receive payment under the growth rate limitations. In establishing such a system, the Secretary could utilize the Health Care Financing Administration, medicare intermediaries, or professional standards review organizations/professional review organizations (i.e. a utilization and quality control peer review organization with a contract under part B of title XI) or other medical review organization to review admissions, discharges, and quality of care for medicare inpatient hospital services.

In addition, hospitals would be required, as a condition of payment under medicare, to enter into, and maintain, an agreement with a utilization and quality control peer review organization which has a contract with the Secretary under part B of title XI to perform review of admissions, discharges and quality of care with respect to medicare inpatient hospital services. The provision would be effective October 1, 1984.

Under the Tax Equity and Fiscal Responsibility Act of 1982, title XI was revised to require the Secretary to contract with peer review organizations in each area of the country. Subject to certain conditions, the Secretary is permitted under title XI to determine which organization in an area will conduct the most effective review. While the new provisions of title XI became effective October 1, 1983, the Secretary has not yet entered into any agreements under this law. Your Committee's bill would make it clear that the Secretary must begin entering into contracts with review organizations under title XI. If the Secretary has not entered into a contract in an area with an organization, there will be no designated organization with which a hospital can enter into an agreement. It is the intent of the provision, that, if there is no designated organization, the hospital will not receive payment under medicare.

Your Committee believes that the new prospective payment system requires a strong system of medicare review and that title XI is the appropriate mechanism for that review. The Secretary has ample time before October 1, 1984, to implement title XI with no adverse effect on medicare payments to hospitals.

Under title XI, medicare intermediaries may be designated as review organizations, but only beginning 12 months after the Secretary has begun to enter into contracts under that title. This delay was intended to provide a preference for medical review organizations. There is concern that the 12 months will not have run before the effective date of your Committee's provision (October 1, 1984). Thus, your Committee's bill provides that the 12 month waiting period for intermediaries to qualify as review organizations (as specified in section 1153(b)(2)) will begin to run on the date on which the Secretary begins to enter into contracts or on October 1, 1983, whichever is earlier. This would assure that the waiting period would be complete by the effective date of your Committee's provisions.

Concern has been expressed regarding the function and duties of medicare intermediaries in their continuing capacity as intermediaries (as opposed to their role as review organizations) and their interaction with designated review organizations. Therefore, your Committee wishes to make it clear that medicare intermediaries will continue to gather, review and analyze medicare claims data. To minimize the administrative costs of the medicare program, the intermediary will supply such information and in such a format, as defined by the Secretary, as is necessary to support the review organization (designated under title XI) in its review function. This could include collection of claims data by diagnostic code, by provider, by patters of admission, or by any other format deemed necessary to support the review organization.

The Secretary would be authorized to disallow payment and/or terminate participation in medicare, or require a hospital to take corrective actions, where a provider is determined to be engaged in aberrant or unacceptable practices. Specifically, your Committee's bill provides that, if the Secretary determines that a hospital, in order to circumvent the prospective payment method or the rate of growth limitations, has taken an action that results in the admission of medicare beneficiaries unnecessarily, or which results in unnecessary multiple admissions of medicare beneficiaries, or results in inappropriate medicare or other practices, the Secretary may (1) deny payment, in whole or in part, for such admission, or (2) require the hospital to take corrective action. Your Committee wishes to make it clear that any denial of payment or termination which occurs under this provision will be subject to the same rights of appeal as provided under current law.

Because prospective payments will be made on a per admission/per discharge basis, your Committee is concerned that there may be an incentive for hospitals to increase their admissions or reduce the quality or availability of care. Accordingly, the Secretary would be provided with this additional authority to deny payment or terminate providers where they are determined to be engaged in unacceptable practices relating to admissions, lengths of stay, quality of care or other forms of circumvention of the payment system.

The Secretary would also be required to study and report back to the Congress before the end of 1985 on long-range policy changes to limit increase in admissions resulting from the prospective system. The Secretary would be required to include analyses and recommendations on adjustments to the DRG payment rate for increased admissions (such as a volume adjustment) and to report on the development of administrative systems, such as pre-admission certification, to minimize the incentive to increase admissions.

8. STATE COST CONTROL PROGRAMS

Under current law, the Secretary has the authority to establish medicare demonstration projects. The Secretary has used this authority to establish State-wide demonstrations for payment of hospital services in four States—Maryland, New Jersey, New York, and Massachussetts.

In addition, the Tax Equity and Fiscal Responsibility Act of 1982 (TEFRA), authorized the Secretary to make medicare payments under a cost control system established in a State if certain conditions were met. While the provision was effective October 1, 1982, the Secretary had not entered into any agreements with States under this authority as of March 1, 1983.

Under your Committee's bill, the Secretary would be authorized to approve a State cost control system (i.e. grant a medicare waiver) if five conditions were met. For those States which currently have an agreement with the Secretary, the Secretary would be required to continue the State program, upon the expiration of the agreement, if, and for so long as, the five conditions were met. Where any other State system met the first five conditions and six additional conditions, the Secretary would be required to approve the State program.

Your Committee's bill provides that the Secretary would be authorized, at the request of a State, to make medicare payments if the following conditions are met: (1) the system applies to substantially all acute-care non-Federal hospitals in the State; (2) the system applies to the review of at least 75 percent of all revenues or expenses in the State for inpatient hospital services (including

[page 365]

Congress is now poised to take the politically expedient way out by merely endorsing the Commission's recommendations with virtually no change.

Make no mistake. The undersigned are totally committed to the necessity of restoring solvency to the Social Security system upon which so many Americans depend. We are not, however, willing to abdicate our principles or responsibility for the sake of helping Congress avoid its legislative role in this issue.

It is unfortunate that our desire to assure the solvency of Social Security into the future cannot be matched by a confidence that this bill accomplishes that goal.

Bill Archer.

* * * * * * *

Phil Crane.

* * * * * * *

HOUSE CONFERENCE REPORT NO. 98-47

* * * * *

[page 115]

JOINT EXPLANATORY STATEMENT OF THE COMMITTEE OF CONFERENCE

The managers on the part of the House and the Senate at the conference on the disagreeing votes of the two Houses on the amendment of the Senate to the bill (H.R. 1900) to assure the solvency of the Social Security Trust Funds, to reform the medicare reimbursement of hospitals, to extend the Federal supplemental compensation program, and for other purposes, submit the following joint statement to the House and the Senate in explanation of the effect of the action agreed upon by the managers and recommended in the accompanying conference report:

The Senate amendment struck out all of the House bill after the enacting clause and inserted a substitute text.

The House recedes from its disagreement to the amendment of the Senate with an amendment which is a substitute for the House bill and the Senate amendment. The differences between the House bill, the Senate amendment, and the substitute agreed to in conference are noted below, except for clerical corrections, conforming changes made necessary by agreements reached by the conferees, and minor drafting and clarifying changes.

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OCT 26 1984

Director
Office of Medical Review

Proposed Policy for Dealing with Premature Discharges and Inappropriate Transfers and Readmissions

Associate Regional Administrators
Health Standards and Quality
Regions I-X

As agreed at our meeting on September 19, I am sending the attached proposed policy statement to you for your reactions. We think the steps outlined in the paper are reasonable and legally supportable. I'd like your thoughts on whether they are workable in the PRO setting. We specifically would like your advice on what should constitute a premature discharge or inappropriate transfer.

After we receive your comments we'll deal with the Office of General Counsel on these issues. We'll need your continued assistance by forwarding cases to us which we can use as examples of why premature discharges and inappropriate transfers are a problem that must be addressed. Please send your comments to Kay Terry within 10 days of receipt of this memorandum. If you have any questions, Mrs. Terry can be reached on FTS 934-7910.

A conference call has been arranged for 2:00 p.m. eastern time November 7 to discuss the criteria that different PROs have been using to identify premature discharges.

Allan Lazar

Attachment

cc: All Regional Administrators

HSQB:DRP:K.Terry:G.Zelinger:gls:9/24/84:1590A:Revised:D.Needel
gls:10/9/84:Revised:K.Terry:gls:10/15/84:Final:Revised:K.Terry
gls:10/19/84:Revised:A.Lazar:gls:10/24/84:Revised:A.Lazar:gls
10/25/84

PRO Policies for Premature Discharges, Transfers, and Inappropriate Readmissions

I. Issue:

How can HCFA remedy the problems of hospitals "gaming" the PPS system and endangering lives through premature discharges, transfers and inappropriate readmissions?

II. Applicable Statute

A. The Social Security Amendments of 1983, Pub.L. 98-21 (the PPS statute) amended the following sections of the Social Security Act (Act) relative to PRO review.

1. Section 1866(a)(1)(F)

Section 1866(a)(1)(F) requires hospitals to contract with PROs to review:

- the validity of diagnostic and procedural information supplied by the provider;
- the completeness, adequacy and quality of care provided;
- the appropriateness of admissions and discharges; and
- the medical necessity and appropriateness of care provided or proposed to be provided for which payment is sought on an "outlier" basis.

2. Section 1886(f)(2)

In its report on the prospective payment legislation, the House Committee on Ways and Means stated that because prospective payments will be made on a per admission/per discharge basis, the committee was concerned that there may be an incentive for hospitals to increase admissions or reduce quality of care. Section 1886(f)(2) requires that

> "if the Secretary determines, based upon information supplied by a Utilization and Quality Control Peer Review Organization under Part B of Title XI that a hospital, in order to circumvent the payment method . . . . has taken an action that results in the admission of individuals, entitled to benefits under Part A unnecessarily, unnecessary multiple admissions or other inappropriate medical or other practices, the Secretary may--

a. Deny payment (in whole or in part) under Part A with respect to inpatient hospital services provided with respect to such an unnecessary admission (or subsequent admission of the same individual; or

b. Require the hospital to take other corrective action necessary to prevent or correct the inappropriate practice."

We are interpreting this to apply both to readmissions to the same hospital and to transfers to another PPS hospital or distinct part (e.g., psychiatric, rehabilitation, etc.) of the same hospital.

B. Section 1156 of the Social Security Act

If a PRO determines that a practitioner or provider has failed in a substantial number of cases to comply substantially with statutory obligations regarding provision of care to Medicare beneficiaries, or has grossly and flagrantly violated any obligation, the PRO must submit a sanction report and recommendation to the Secretary. If the Secretary agrees with the PRO's recommendation, the Secretary may exclude the provider or practitioner from participating in the Medicare program.

III. Nature of the Problem

We are becoming increasingly aware, through reports submitted to regional offices by PROs and through other anecdotal evidence, that some hospitals are circumventing the prospective payment system through inappropriate transfers, inappropriate diagnostic testing, and premature discharges, leading to readmissions. Although collection of actual cases and data analysis continues, we believe there is strong enough evidence at this point that inappropriate transfers, premature discharges and other inappropriate readmissions have occurred—that patients have been harmed, and/or "gaming" of the system has occurred.

IV. PRO Review Policy

Medical Review Entities (MREs) are presently reviewing all transfers from PPS hospitals to: PPS-exempt rehabilitation units, alcohol/drug treatment units, swing beds, and other hospitals (PPS and non-PPS). MREs also review a sample of the transfers from PPS hospitals to PPS-exempt psychiatric units. The purpose of this review is to determine whether the care given to the transferred patient is provided in the appropriate setting and whether the reason for the transfer is medically necessary and appropriate. MREs also review all readmissions within 7 calendar days of discharge from an acute hospital (which are related to the previous admission). The purpose of the readmission review is to determine whether the initial and subsequent admission were medically necessary and appropriate. MREs also determine whether the second admission resulted from a patient being prematurely discharged from the first admission or from the inappropriate scheduling of diagnostic tests.

The MRE must first analyze medical records and document completely the occurrence of a premature discharge, other inappropriate readmission, or inappropriate transfer. Documentation of premature discharge should include evidence in the chart that the patient is not medically stabilized or ready to leave the hospital or that test results indicate the patient should have remained in the hospital for further testing or treatment. Signs and symptoms present in the chart on the day of discharge, such as elevated temperature, post-operative wound drainage or bleeding, or abnormal laboratory studies, are indicators that a patient was prematurely discharged from the hospital. An inappropriate discharge would be indicated by a quick readmission, with no supporting evidence.

Inappropriate reasons for readmission (other than premature discharge) could be the case where diagnostic tests are performed during the initial stay and the results indicate further treatment is needed: instead of performing the additional services at that time, the patient is discharged and readmitted at a later date, or test results may not be completed before discharge and the patient is later readmitted to complete treatment called for in the results. In either case, the patient is not necessarily harmed - the PPS system is, however, circumvented. Documentation of an inappropriate reason for transfer would include a finding that there is no medical basis for transferring a patient to another hospital in the same vicinity as the first hospital.

V. Suggested Interventions

It is the PRO's responsibility to take intervention commensurate with the nature of the provider's inappropriate action. We intend to include the following interventions in the scopes of work (and/or in administrative issuances) of all PRO contracts. We will take this action based on the authority contained in Sections 1866(a)(1)(F), 1886(f)(2) and 1156 of the Act. Actions could be as follows; not necessarily in sequential order.

- Denials

  We believe that under section 1886(f)(2) and the PRO statute, PRO denials for readmissions due to premature discharges or inappropriate transfers can only be made in instances where the patient is admitted and readmitted to the same hospital or where the patient is transferred to an excluded unit of the same hospital. In both these instances, if a PRO finds that a hospital prematurely discharged a patient, which resulted in a subsequent readmission to the same hospital, or that the hospital transferred a patient inappropriately to an excluded unit in the hospital (i.e., the patient was too sick to be transferred or the patient did not require the services of the excluded unit), the PRO will issue a denial of the readmission or transfer (i.e., the PRO will deny payment for the second admission).

  For example, PROs should deny the second admission where the patient is discharged and readmitted because test results indicate the patient should have remained in the hospital for further testing (and the patient treated during a single stay).

  As the waiver of liability provisions do not apply to denials under section 1886(f)(2), the PRO will deny these cases and move to consideration of sanctions if initial interventions fail to correct the problems (see below).

  However, admissions to a different hospital after a premature discharge or inappropriate transfer should be treated by a PRO as a quality problem and not result in a denial. Instead, they should be addressed by the PRO in quality objectives and the interventions outlined below should be initiated.

- Intensified Review

  Where PROs determine that a practitioner has prematurely discharged or inappropriately transferred one patient, the PRO should review 100 percent of the physician's discharges and transfers for one quarter. If no other instances occur, the PRO will remove intensified review at the end of that quarter. If now and then one instance occurs, the PRO should move to other interventions.

- Sanctions

In certain circumstances, PROs should initiate a sanction report and recommendation against a practitioner or provider for premature discharges or inappropriate transfers. If a premature discharge or inappropriate transfer causes a patient's death or results in permanent loss of a major physical function, the PRO should immediately initiate a sanction based on a "gross and flagrant" violation of the physician's Medicare obligations. In other cases where a provider or practitioner is responsible for two instances of premature discharge or inappropriate transfers in a single quarter, the PRO should consider initiating a sanction report and recommendation based on a "substantial number of abuses." If three instances occur in a quarter, the PRO must initiate sanctions.

- Survey and Certification

As a requirement for participation in Medicare, all hospitals must comply with the condition of participation that requires the medical staff of the hospital to review hospital discharges. Therefore, premature discharges may be a certification issue in addition to being a medical review performance problem. The PRO should report any hospital in which two or more physicians have been placed on intensified review or where a sanction report is initiated to the HCFA regional office which will notify the survey and certification reviewers that there is a potential problem with a particular hospital. If the surveyers identify sufficient problems, the hospital will lose its Medicare certification status.

- Fraud or Abusive Practices

In some instances, the PRO may suspect that fraud or an abusive practice is involved in cases involving transfers and readmissions. For example, a hospital submits two separate claims for a given patient, as if the patient were readmitted to the hospital. However, the PRO may find that the patient was never really discharged from the hospital. Also, two hospitals may be identified as having an unexplained pattern of Medicare transfers between them. In such instances, the PRO should refer individual cases to the Regional Office of the Inspector General for further investigation.

HSQB:DRP:D.Needel:gls:9/21/84:Put on Jerry's Disk #6.:1565A
Revised:K.Terry:9/24/84:gls:Revised:D.Needel:gls:10/9/84
Revised:D.Needel:gls:10/11/84:Revised:K.Terry:gls:10/15/84:Final

Jo DG

Iowa Foundation for Medical Care
Colony Park
3737 Woodland Avenue, Suite 500
West Des Moines, Iowa 50265
515/223-2900

December 28, 1984

Frank Kram, Regional Representative
Office of Health Financing Integrity
1100 Main Street, P.O. Box 26248
City Center Square, Suite 615
Kansas City, Missouri 64196

Dear Frank:

The Comprehensive Review Committee (CRC) of the Iowa Foundation of Medical Care has completed a preliminary review of Hospital in .

The committee reviewed the cases which were referred to us by your office and have determined that more intensive evaluation is necessary. With the information provided, it appears that not all of the procedures performed were medically necessary.

Due to the different physicians involved in these cases, the CRC has recommended that more extensive review be conducted of all physicians on the medical staff at Hospital. Beginning January 15, 1985, the entire medical staff will be required to preadmission screen 100% of their Medicare patients followed by 100% DRG validation. All necessary physician peer review will be conducted by physicians external to the hospital.

The committee also recommended that a physician assessment be conducted at the hospital within the next 30 days. This is tentatively scheduled for January 10, 1985.

The last item the committee recommended was to seek approval from HCFA to conduct preprocedure review of all pacemakers, angiograms, bronchoscopies, mediastinoscopies, gastrointestinal endoscopies and cystoscopies performed on an outpatient basis. We have discussed this with Ben Gruber and he advised us to contact you regarding this issue.

As we continue with our review, we will keep you apprised of our findings. In the meantime if you have further questions, please call Becky Hemann.

Sincerely,

Fred

Fred Ferree
Executive Vice President

FF:jd

cc: Ben Gruber

ndhcri
north dakota
health care review, inc.
900 n. broadway, suite 212
minot, north dakota 58701
(701) 852-4231

January 4, 1985

NDHCRI INCIDENCE REPORT TO REGIONAL OFFICE

Patient Name: [redacted] HIC NO: [redacted] Admit Date: 9/2/84
Hospital Name: [redacted] MPR No. [redacted] [redacted]
Physician Name: [redacted] License No: [redacted] Reviewer Numbers:
R.S. 03 - P.A. [redacted] Reviewed: 12/20/84

Incidene Type:

_X_ A. Readmission Subsequent to a Premature Discharge
___ B. Transfer of a Questionable Nature
___ C. Hospital Initiated Denial Not Reported on Monthly List
___ D. Inappropriate Hospital Initiated Denial Issued Prior to DRG ALOS

(Narrative description of the problem or discrepancy using as accurate direct language as possible. Use physicians orders and physician advisor notes for quotations where possible.)

According to the physician advisor "this patient was readmitted to the hospital on the same day as he was discharged because of urinary bladder retention due to prostatic hypertrophy. This man was admitted to the hospital with prostatic hypertrophy and bladder neck obstruction and was then sent home rather than referred for urological consultation. He was sent home and returned back to the hospital and had to be catheterized again with an indwelling Foley catheter. Again, he was kept in the hospital for two days before the decision was made to refer this man to a urologist. This man should have been referred to a urologist during the first admission and the second admission should not have been made. The patient should have been sent to a specialist after a Foley catheter was placed on the first admission".

Distribution

NDHCRI
Regional Office
Hospital
Attending Physician

HCFA/HSQ Received JAN 7 '85

Iowa Foundation for Medical Care
Colony Park
3737 Woodland Avenue, Suite 500
West Des Moines, Iowa 50265
515/223-2900

BG-
Action

January 15, 1985

Mr. Ben Gruber
Division of Health Standards and Quality
Region VII
Federal Office Building
601 East 12th Street
Kansas City, Missouri 64106

Subject: Contract Modification
Contract Number: 500-84-0513
Correspondence: 85-20

Dear Ben:

As you know, we have been requested by the Inspector General to investigate Hospital in . We have completed a preliminary review and we are continuing our investigation of the hospital.

Because this entails additional review and may result in a sanction recommendation, we are requesting a contract modification and additional funds for this review.

Our current plan for this review was outlined in our letter of December 28, 1984, addressed to Frank Kram. This includes 100% preadmission review and 100% DRG validation for the entire medical staff. We also requested that we be able to conduct preprocedure review of selected procedures when performed on an outpatient basis. You have mentioned that Frank will be notifying us to proceed with this review.

Attached is an estimate of the funds required to complete this review.

We look forward to hearing from you. In the meantime, if you have any questions, please call me.

Sincerely,

Fred

Fred Ferree
Executive Vice President

FF:jd

Attachment

cc: Burton Steckler

Estimated Expenses

Currently there are an average of 45 Medicare admissions per month or 135 per quarter. Usually approximately 50 percent of their discharges would be reviewed on a concurrent basis. However, problems identified by the PRO in conjunction with the Inspector General's Office necessitate 100 percent review of inpatient and outpatient services. Anticipated additional expenses for each quarter of intensified review are detailed below.

I. Staff Review Activities

A. Admission Review - 135 cases x 12 min/per review
= 27 hours per quarter x .50 (additional review time) = 13.5 hours.
13.5 hours x $11.28 = $152.30 per quarter
$152.30 x 3 quarters = $456.90

B. DRG Validation - 135 cases x 20 min/per review
= 45 hours (this is an additional 36.5 hours)
36.5 hours x 11.28 = $411.72 per quarter
$411.72 x 3 quarters = $1235.16

C. Outpatient Review- 45 cases x 12 min/per review
= 9 hours x $11.28 = $101.52 per quarter
$101.52 x 3 quarters = $304.56

D. Management and Administrative Support based on direct labor estimates - $5.78 per discharge reviewed (135) = $780.30 x 50 percent = $390.15 for inpatient review.
$5.78 x 45 cases = $260.10 for outpatient review.
$650.25 x 3 quarters = $1950.75

Total Staff Review Activities - $3947.37

II. Physician Review Activities

- 50 percent of all preadmission and DRG validation will be referred to physician review.
- All outpatient reviews will be referred to physician peer review.

A. Admissions - 67 cases x 5 min. = 5.5 hours
(this is an additional 3.5 hours)
3.5 hours x $54 = $189
$189 x 3 quarters = $567.00

Holy Family, Estherville
Estimated Expenses
Page # 2

B. DRG Validation - 67 cases x 10 min. = 11 hours
(this is an additional 9 hours)
9 hours x $54 = $486
$486 x 3 quarters = $1458.00

C. Outpatient - 45 cases x 5 min. = 3.75 hours
3.75 hours x $54 = $202.50
$202.50 x 3 quarters = $607.50

D. Physician Consulting - Retrospective Medical Record Review -
50 cases x 15 min. x 3 physicians =
37.5 hours x $54 = $2025

Total Physician Review Activities - $4657.50

III. Committee Expenses

Subcommittee- $1188 Initial meeting (5 members)
500 Second
500 Third
$2188

CRC - 1.5 hours x 13 members x $54 = $1053

Board - 1 hour x 32 members x $54 = $1728

Total Committee Expenses - $4969

IV. Physician Travel Expenses

Miles - 800 miles x .225 per mile = $180

Airfare - $1200 x .75% (Medicare) = $900 (Hospital Visit)

Total Physician Travel Expenses - $1080

V. Legal Expenses

50 hours x $80/hr. = $4000

Total Legal Expenses - $4000.00

Estimated Expenses

I.	Staff Review Activities	$3947.37
II.	Physician Review Activities	$4657.50
III.	Committee Expenses	$4969.00
IV.	Physician Travel Expenses	$1080.00
V.	Legal Expenses	$4000.00
	TOTAL	$18,653.87

MAINE Society of
EYE PHYSICIANS and SURGEONS
325-A Kennedy Memorial Drive
Waterville, Maine 04901 Tel. (207) 873-2731

William E. Clark, Jr., M.D.
President
Robert H. Nicholson, M.D.
Vice-President
Robert Takach, M.D.
Secretary-Treasurer

January 17, 1985

Michael A. LaCombe, M.D.
State Director of the Peer Review Organization
Health Care Review, Inc.
17 Winter Street
Norway, ME 04268

Dear Dr. LaCombe:

I am writing you regarding the new Peer Review Organization requirements involving those patients who are scheduled to undergo cataract surgery. As you are aware, as outlined on page 18 of the Health Care Financing Administration (HCFA) contract, the plan is to "Reduce by 90%...unnecessary Medicare hospital admissions for selected diagnostic and/or therapeutic invasive procedures that can be performed effectively and with adequate assurance of patient safety in an ambulatory surgical setting." These regulations will be enforced by retrospectively denying the Medicare patient's hospital coverage. This in no way represents a financial problem for the physician per se. We are compensated in the same manner whether or not the patient is hospitalized or treated as an outpatient.

Many individuals are outpatient candidates for cataract surgery. They have the desire, understanding, and physiological makeup necessary to cope with this situation. They have help from other individuals, such as friends or family, giving them the support and care necessary to make it through the early recovery period. They are prepared and able to make the required follow-up visits to the office. These follow-up visits are essential in order to maintain proper postoperative care; it is mandatory that the patient be seen on the day following surgery and often on several days afterwards. It is even possible that they may have to be seen several times in the same day.

Other individuals are definitely not candidates for outpatient surgery. Let me give you several examples.

Example 1. An elderly individual requires either general anesthesia or sedation in order to control her during time of surgery and at time of discharge appears to be fairly stable, but is obviously still going through delayed recovery period. She returns to her home 30 miles away to a confused spouse for recovery care, then must return the following day for follow-up examination.

Example 2. A monocular, or one-eyed individual who lives alone has to go home with a patch over his only seeing eye, essentially making him "blind". He must care for himself during the night and return "blind" to the office the following day.

Example 3. A patient has surgery in the morning, and by afternoon when he has recovered, a blizzard arrives in the area. The patient is advised that he must be discharged, not only to travel to his home or a motel, but then return to the office the following day.

Example 4. A mentally or physically handicapped patient who lives alone, without friends or family, has had postoperative care explained carefully to him prior to and after surgery, but is still questionably capable of initially carrying it out.

Example 5. An anxiety-ridden patient states that she comprehends what is going on, but in truth obviously does not understand the situation. Even minor problems,which appear to be simple, become overwhelming for her.

Example 6. A patient with multiple medical problems, such as cardiac disease, chronic pulmonary disease, or diabetes mellitus - controlled, undergoes cataract surgery. When examined individually, these medical problems may appear stable and not create a postoperative difficulty for the patient, but when taken together may cause a major hazard. Even the routine daily medication schedule may become confusing. This individual might just need monitoring through the night in order to be certain that he or she is stable at time of discharge.

Example 7. An indigent family or a family who is "just getting by" is forced to take several days off work in order to travel 90 miles to bring their elderly parent to the hospital for surgery and must remain in the area for several days until the patient stablizes.

Example 8. A patient undergoes uneventful cataract surgery with intraocular lens implantation, is discharged, and travels to his home 60 miles away. He develops severe pain in the eye early that morning and is unable to return to the ophthalmologist's care due to the inability to obtain transportation, and being "too sick to move". When seen the following day, is found to have an acute postoperative glaucoma and has substained marked visual loss secondary to this problem - something which could have been treated if the patient were in the hospital.

Example 9. An individual will frequently need the comfort, support and reassurance of professional recovery care. He or she may need medications throughout the night for nausea, pain or close observation if they are confused. The hospital is the obvious answer to this situation. Very frequently these complications do not arise until several hours after surgery.

Obviously in many instances cataract surgery should require hospitalization in order to avoid major complications. The immediate post operative period is extremely critical in the patient's care as some of the greatest risks that the patient will face are problems that could arise within the first 24 hours. Such complications would include wound leakage with a flat anterior chamber, post operative bleeding resulting in hyphema, post operative secondary glaucoma or an endophthalmitis (a massive infection within the eye). These are all potentially blinding complications. This list, of course, does not include the lesser problems that a patient might face, that of pain, confusion, fear, nausea or the difficulty of caring for oneself when faced with markedly restricted vision. This list could include the patient's general care such as taking one's medications and even the difficulty with ambulation. Also, untoward movement, stress and strain or riding for a prolonged period over bumpy roads might exacerbate these complications within the immediate postoperative period. The patient must also contend with the side effects of preoperative analgesics along with the after effects of anesthesia.

Essentially we are being told to ignore the social, mental and physical well being of the patient. We are being advised that other considerations such as weather, travel and personal financial problems are no longer an intregal part of total patient care. Good medical judgement no longer is applicable.

Maine is a geographically large rural state with one of the lowest per capita incomes in the nation. It is fairly obvious that regulations that apply in one state may not necessarily apply in another. The Federal Government, in signing into the law the Social Security Amendments Act of 1983, brought into effect the Prospective Payment System (PPS) for hospitals. This created many categories called Diagnostic Related Groups or DRGs. It was felt by the Federal Government that the mean length of hospital stay for cataract surgery was 2.8 days. The Peer Review Organization is now telling us that this no longer applies. Forcing outpatient surgery is more than a personal hardship for the patient. It has the potential of lessening the possibility of a good surgical result. It is the compromising of patient care, and especially of the patient's safety that is at stake.

I would like to request that this discrimination against the ophthalmologic patient be recinded. It should be up to the physician's discretion whether or not to admit the patient. The patient should at least be allowed to remain in the hospital for the original Diagnostic Related Group mean length of stay for cataract surgery of 2.8 days as was originally dictated by the law. Unfortunately, if the present regulations as prescribed by the Peer Review Organization persist, the patients, especially the elderly, the handicapped, and the indigent, will be made to suffer the most in this new system.

I would like to close with a quote from the Oath of Hippocrates.

> "I will follow that method of treatment which, according to my ability and judgement, I consider for the benefit of my patients, and abstain from whatever is deleterious and mischievous."

Thank you for your consideration of this very important problem. I feel that it represents a grave threat to the health care of the people of Maine as well as the rest of the nation. I shall anxiously await your response.

Sincerely,

William E Clark, Jr MD

WILLIAM E. CLARK, JR., M.D.
President, Maine Society of Eye
Physicians and Surgeons

WEC:nr

cc: Frederick S. Crisafulli, M.D.

DEPARTMENT OF HEALTH & HUMAN SERVICES

Memorandum

Date JAN 18 1985

From Carolyne K. Davis, Ph.D. Carolyne K Davis
Administrator
Health Care Financing Administration

Subject Office of the Inspector General (OIG) Priority Inspection Report--Inappropriate Readmission and Transfer Practices under the Prospective Payment System (PPS)

To The Inspector General
Office of the Secretary

As the OIG report points out, current HCFA instructions (i.e., Transmittal #107) to Utilization and Quality Control Peer Review Organizations (PROs), which are responsible for identifying instances where Medicare patients are involved in inappropriate hospital readmissions or transfers, require the PRO to deny payment for "non-covered" admissions, readmissions and transfers. Other cases which may involve inappropriate readmissions or transfer practices are referred to the regional office for review. The regional offices are submitting these cases to central office for use in developing appropriate review policies. In addition, as one of their quality objectives, PROs are currently intervening and correcting situations where unnecessary readmissions are occurring because of substandard care provided during a prior hospital admission.

We agree with the OIG report that HCFA's instructions should be revised, as soon as possible, to require PROs to make denials or to require corrective actions, such as sanctions, in readmission and transfer cases involving medically inappropriate practices. In order to develop specific policies in this area, we sent a draft memorandum to the regional offices on October 26, 1984 for comments and conducted a conference call on November 14 with the regions. Based on their input and further analysis we are developing program guidance which outlines specific situations and specific interventions that must be taken where inappropriate readmissions or transfers are identified. I have instructed my staff to consult with appropriate members of your staff in developing policy papers in this area.

Additionally, in the next year, we expect to publish regulations changing the method by which transfer cases between PPS hospitals are paid. It has always been our stated intention to make one payment for the entire course of inpatient hospital treatment to the final discharging hospital. The hospitals involved in the course of treatment would have to negotiate the distribution of the prospective payment amount. This mechanism should be a disincentive to the unnecessary transfer of patients since the transferring hospital no longer would receive a per diem payment but would be subject to negotiating a share of the final payment with another hospital. (This proposal would not apply to hospitals or units that are excluded from PPS.)

Should you have any questions, please contact Linda Schmidt on FTS 934-7491.

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✓
Mr. Stene
✓
Thole

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NEBRASKA FOUNDATION FOR MEDICAL CARE, INC.
Suite 801 CTU Building
1221 N Street
Lincoln, Nebraska 68508

Telephone: (402) 474-7471

January 29, 1985

Mr. Phillip Gomez
Contract Specialist
Department of Health and Human Services
Health Care Financing Administration
DPS/Contract Branch - RFP-HCFA-84-015
Room 322, East Highrise Building
6325 Security Boulevard
Baltimore, MD 21207

HEW
HCFA-HSQ
REGION VII
~~Mar 26~~ April 1 46 PM '85

RE: HCFA# 500-84-0529
0013

Dear Mr. Gomez:

NFMC received a letter from Gregory A. Lear, Chief, Medical Review Branch, Kansas City Regional Office. This letter included a copy of PRO Program Directive No. 5 and a statement that contract modifications for this additional review will be issued shortly.

NFMC wants to do whatever we can to comply with the existing PRO contract and any mutually agreed upon modifications between NFMC and HCFA. In order to modify the contract, it will be necessary to obtain NFMC Board of Director approval. Their review and approval will depend on our ability to evaluate the impact of additional review and reporting compared to any reduction in work load or increased financing.

NFMC is unable to evalute the impact of the proposed additional work load. Further, we have no idea as to what HCFA proposes to offset the additional work load. As soon as we are able to evaluate this information, it will be presented to our Board of Directors for consideration. Hopefully, we can obtain HCFA's proposal with enough lead time to evaluate the proposal and prepare a recommendation to the Board of Directors.

Thank you for any assistance you can be in this matter.

Sincerely,

Kenneth E. Neff

Kenneth E. Neff
Executive Director

xc: Ben Gruber
Gregory A. Lear

BB

THE KANSAS FOUNDATION FOR MEDICAL CARE INC.
2953 S.W. Wanamaker Drive / Topeka, Kansas 66614
Telephone: (913) 273-2552

January 29, 1985

Ms. Elizabeth A. Faykus
Contract Specialist
Department of Health and Human Services
Health Care Financing Administration
DPS/Contract Branch - RFP-HCFA-84-015
Room 322, East Highrise Building
6325 Security Boulevard
Baltimore, MD 21207

RE: HCFA #500-84-0506
0054
PRO Program Directive No. 5

Dear Ms. Faykus:

We received a letter from Gregory A. Lear, Chief, Medical Review Branch, Kansas City Regional Office. This letter included a copy of PRO Program Directive No. 5 and a statement that contract modifications for this additional review will be issued shortly.

We want to do whatever we can to comply with the existing PRO contract and any mutually agreed upon modifications between KFMC and HCFA. In order to modify the contract, it will be necessary to obtain KFMC Board of Director approval. Their review and approval will depend on our ability to evaluate the impact of additional review and reporting compared to any reduction in work load or increased financing.

We are unable to evaluate the impact of the proposed additional work load. Further, we have no idea as to what HCFA proposes to offset the additional work load. As soon as we are able to evaluate this information, it will be presented to our Board of Directors for consideration. The next KFMC Board of Directors meeting is scheduled for February 17, 1985. Hopefully, we can obtain HCFA's proposal in time to evaluate the proposal and prepare a recommendation to the Board of Directors.

Thank you for any assistance you can be in this matter.

Sincerely yours,

Larry W. Pitman
Executive Director

LP/ngd

xc: Brenda Burton ✓
Gregory A. Lear

ndhcri
north dakota
health care review, inc.
900 n. broadway, suite 212
minot, north dakota 58701
(701) 852-4231

January 31, 1985

NDHCRI INCIDENCE REPORT TO REGIONAL OFFICE

Patient Name: [redacted] HIC No.: [redacted] Age: 88
Admission Date: 11/19/84 Hospital Name: [redacted] MPR No. [redacted]
Physician Name: [redacted] M.D. License No.: [redacted]
Reviewer Numbers: R.S. [redacted] and P.A. [redacted] Reviewed: 1/25/85

Indicence Type:

___ A. Readmission Subsequent to a Pre-Mature Discharge
_X_ B. Transfer Of a Questionable Nature
___ C. Hospital Initiated Denial Not Reported on Monthly List
___ D. Inappropriate Hospital Initiated Denial Issued Prior to DRG ALOS

Narrative description of the problem or discrepancy using as accurate direct language as possible. Use physicians orders and physician advisor notes for quotations where possible.

This patient was admitted on 11/8/84 for CHF and cardiac dysarrthymias, the attending physician [redacted] The patient was transferred to [redacted] on 11/13/84 under the care of [redacted] for treatment of severe cardiac failure. A permanent pacemaker was inserted and the patient was stabilized and transferred back to [redacted] Bottineau on 11/19/84. The record states "this 88 year old female was brought back from [redacted] pacemaker in place and working with little or no change in her general status. She was in severe failure with weakness and severe dyspnea". The patient expired on 11/25/84. NDHCRI [redacted] reviewed this case and his comments are as follows: "....after review of this record I am unable to find justification for transfer of this patient back to [redacted]. The patient could have been treated just as effectively at [redacted].

Distribution

NDHCRI
Regional Office
Hospital
Attending Physician

ndhcri

north dakota
health care review, inc.
900 n. broadway, suite 212
minot, north dakota 58701
(701) 852-4231

January 31, 1985

NDHCRI INCIDENCE REPORT TO REGIONAL OFFICE

Patient Name: [redacted] HIC NO.: [redacted] Age: 69
Admission Date: 09/13/84 Hospital Name: [redacted] MPR No. [redacted]
Physician Name: [redacted] M.D. License No.: [redacted]
Reviewer Numbers: R.S. [redacted] - [redacted] Reviewed: 01/14/85

Incidence Type:

___ A. Readmission Subsequent to a Pre-Mature Discharge
_X_ B. Transfer Of a Questionable Nature
___ C. Hospital Initiated Denial Not Reported on Monthly List
___ D. Inappropriate Hospital Initiated Denial Issued Prior to DRG ALOS

Narrative description of the problem or discrepancy using as accurate direct language as possible. Use physicians orders and physician advisor notes for quotations where possible.

This 69 year old female was diagnosed as "chronic granulocytic leukemia" in October of 1983. "At that time she had been hospitalized for three months in [redacted]" On both the discharge and admission summaries it is noted that she "was transferred here so that she could be closer to her family and relatives".

There does not appear to be a medical reason for this transfer.

Distribution:

NDHCRI
Regional Office
Hospital
Attending Physician

HCFA/HSQ Received FEB 7 '85

COLORADO FOUNDATION FOR MEDICAL CARE

REFERRALS TO REGIONAL OFFICE

READMISSIONS

The CFMC has requested that the hospital Medical Audit Committee address the premature discharge/quality of care in each of the following cases. The hospital is expected to respond within 30 days indicating their review decision and the corrective action to be taken, if any deemed necessary by the audit committee.

CFMC REGION II

CASE #1 AND #2

The patient had a long standing history of chronic obstructive pulmonary disease which resulted in several admissions over a short period of time. Of the several admissions, two (2) were considered to be as a result of premature discharge. The blood gases on discharge showed little improvement over the course of the hospitalizations. Because the patient lived alone she would become anxious easily and was admitted for increasing difficulty in breathing. Presently, the patient is in a nursing home which is the proper placement given her condition.

CFMC REGION III

CASE #3

The patient met criteria for both admissions. During the first hospitalization, bleeding from the colon was identified. Only an upper gastrointestinal study was completed. On the day of discharge, the nurse notes stated that the patient "passed a loose black stool". The physicians notes stated that the patient's "condition was deteriorating". The patient was readmitted the day after discharge and found to be actively hemorrhaging.

READMISSIONS

The CFMC has requested that the hospital Medical Audit Committee address the premature discharge/quality of care in each of the following cases. The hospital is expected to respond within 30 days indicating their review decision and the corrective action to be taken, if any deemed necessary by the audit committee.

CFMC REGION III

CASE #1

Premature Discharge

The patient was prematurely discharged from the first admission due to the failure of proper discharge planning in arranging oxygen at home. The patient was hospitalized for seven days on the second admission until home oxygen was arranged.

CASE #2

Premature Discharge

The patient was treated for an antero-inferolateral myocardial infarction receiving Lidocaine for PVCs. The PVCs were still documented three days prior to discharge. The medical record did not reflect documentation of cardiac rehabilitation. Four days after discharge, the patient was readmitted with an extension of the myocardial infarction and treated in CCU for two days.

COLORADO FOUNDATION FOR MEDICAL CARE

REFERRALS TO REGIONAL OFFICE
(TRANSFERS & READMISSIONS)

CONTINUED

Premature Discharge

CASE #3

Patient admitted through E.R. and received depomedral for pericardial disease. Patient was discharged and readmitted one day later for same therapy. Patient should have been stabilized before discharge. The second admission was denied.

CFMC REGION V

Premature Discharge

CASE #4

The patient was initially admitted with pneumonia and treated with I.V. antiobiotics.

At the time of discharge, the patient stated he felt very anxious about going home and still felt very weak. No repeat chest x-ray was done prior to discharge. Two days later, the patient was readmitted with an elevated temperature and pneumonia. Two days after admission the patient went into adult respiratory distress and died shortly therafter.

The attending physician and the hospital administrator were notified that this case was determined to be a premature discharge.

Reporting Date: 2 / 1 / 85

NDHCRI INCIDENCE REPORT TO REGIONAL OFFICE

Patient Name: [redacted] HIC NO. [redacted] Age 83

Admit Date: 9/ 15 / 84 Hosp. Name [redacted] MPR No.35[redacted]

Physician Name: [redacted] M.D. License No.: [redacted]

Reviewer Numbers: R.S. [redacted] P.A. [redacted] Reviewed: 1 / 2 / 85

Incidence Type:

_X_A. Readmission Subsequent to a Pre-mature Discharge
___B. Transfer Of a Questionable Nature
___C. Hospital Initiated Denial Not Reported on Monthly List
___D. Inappropriate Hosp. Init. Den. Issued Prior to DRG ALOS

(Narrative description of the problem or discrepancy using as accurate direct language as possible. Use physicians orders and physician advisor notes for quotations where possible.)

This patient was admitted on 9/15/84 for COPD. The attending physician license number is [redacted]. The patient was discharged on 9/27/84. At the time of discharge the record states "There is a deterioration in the chest when compared to the previous study of 9/19/84." "Increasing pulmonary infiltrates and consolidation has occurred with obliteration of the right diaphragm." The patient was readmitted on 9/29/84 with a diagnosis of COPD and right lower lobe pneumonia. The patient expired on 9/30/84. NDHCRI [redacted] reviewed this case. His comments are as follows: "After review of this case I find that the patient should not have been discharged in the presence of a deteriorating chest x-ray."

Distribution - Type	A B C D
NDHCRI	A B C D
Regional Office	A B C D
Hospital	A B C D
Attending Physician	A B C D
Fiscal Intermediary	D
Patient	D

HCFA/HSQ Received FEB 7 '85

Iowa Foundation for Medical Care
Colony Park
3737 Woodland Avenue, Suite 500
West Des Moines, Iowa 50265
515/223-2900

February 5, 1985

Burton Steckler
Health Care Financing Administration
Contract Branch, DPS
East High Rise Bldg. Room G-10-A
6325 Security Boulevard
Baltimore, Maryland 21207

Dear Mr. Steckler:

We have reviewed PRO Directive #5 regarding the review of DRG 462's. This review activity will affect our review activity and the cost of our contract.

As addressed in Article XXIV of our PRO contract, we are requesting additional funds to perform this review activity. All of these cases will require physician review because these are questionable admissions.

If you have any questions, please contact me.

Sincerely,

Fred Ferree
Executive Vice President

FF:jd

cc: Ben Gruber

UNITED STATES GENERAL ACCOUNTING OFFICE
WASHINGTON, D.C. 20548

PROGRAM EVALUATION
AND
METHODOLOGY DIVISION

21 FEB 1985

B-217732

The Honorable John Heinz
Chairman, Special Committee
on Aging
United States Senate

Dear Mr. Chairman:

Subject: Information Requirements for Evaluating the Impacts of Medicare Prospective Payment on Post-Hospital Long-Term-Care Services: Preliminary Report (GAO/PEMD-85-8)

On February 12, 1985, you asked us to provide a preliminary report on our study of the information needed to assess the impacts of the Medicare prospective payment system (PPS) on post-hospital long-term care. You expressed a particular interest in a statement and explanation of the key issues. We have identified four key issues:

1. Have patients' post-hospital care needs changed?
2. How are patients' needs being met?
3. Are patients having access problems?
4. How have long-term-care costs been affected?

In addition to these key issues, we found that the long-term-care community is concerned about whether Medicare is adequately apprising beneficiaries of the changes brought on by PPS and whether Medicare is appropriately administering coverage determinations.

PPS was intended to control Medicare hospital costs. This reimbursement system, which is based on fixed payments for diagnosis-related groups, provides hospitals with incentives to limit costs incurred for each Medicare patient by carefully controlling the amount of services provided or limiting length of stay or both. Although there is concern that these actions could adversely affect the quality of care, experts have argued that some reduction in hospital services or length of stay and costs is possible without sacrificing quality. Shorter hospital stays might also, in some cases, reduce patients' risk of infection and provide them with additional positive benefits.

(973581)

However, experts have also expressed a variety of concerns about the possible effects of PPS on the quality of care. Among the most important are that some discharges from the hospital may be premature, the availability and affordability of the appropriate follow-up care may not be guaranteed, and the medical needs of patients referred to nursing homes, home health care, and other forms of care provided in the community could be greater than providers are equipped to handle. In addition, it has been argued that increases in Medicare patients' use of long-term-care services could partially or fully offset the savings in hospital costs and thereby affect total Medicare costs. Changes brought on by PPS might also increase the costs of other public programs, particularly Medicaid, and the costs incurred by individual Medicare beneficiaries and their families.

OBJECTIVES, SCOPE, AND METHODOLOGY

In 1984, we initiated a study designed to identify the information that is necessary for addressing the key post-hospital issues associated with PPS. The objectives of this study are to

1. identify and develop the key issues related to the post-hospital care of Medicare patients given currently available information and the experiences of individuals with firsthand knowledge of prospective payment systems and

2. review the data collection and analysis under way or planned by the U.S. Department of Health and Human Services (HHS) to address the key issues and to determine whether additional work or refinement to ongoing work is needed to insure that the information the Congress needs to address the key issues will be available, valid, and timely.

Our work on the first objective, the development of the key issues, is complete. Our work on the second objective, reviewing the activities of HHS in data collection and analysis, is nearing completion. This preliminary report focuses on our assessment of the most important issues that HHS should address in evaluating the impacts of PPS on post-hospital care.

We identified potential issues from four broad sources of information. First, a review of the literature and research, including our earlier reports, helped us define the potential issues. In addition, we met with HHS officials and other experts on health care financing and health services research. Second, group discussions with representatives of national associations of hospitals, nursing homes, home health care agencies, and advocates for the elderly helped us better understand their perspectives on the issues. Third, short visits were made to six communities in July 1984 (Adrian, Michigan; Corpus Christi, Texas; Orlando, Florida; Pittsburgh, Pennsylvania; Richmond, Virginia; and Seattle, Washington). These visits allowed us to talk to local providers of care (representing hospitals, home health agencies, and skilled nursing facilities) as well as representatives of advocate groups, health-planning agencies, and peer-review organizations. We asked them to tell us, from their experience, how they expected PPS to affect long-term care. Fourth, we conducted telephone interviews with program officials and health industry experts in Maryland, Massachusetts, New Jersey, and New York, the states that have been granted waivers from PPS because they have implemented alternative prospective payment systems.

The site visits were important in helping us develop the issues. Of course, our discussions at any one site were not necessarily representative of the views of the entire community or of its specific providers or consumers. However, we selected our sites carefully in order to achieve a wide coverage of the issues that are believed to be important. The criteria we used for selecting the sites were average length of stay in acute-care hospitals, the availability of nursing home beds, certificate-of-need regulations for establishing home health agencies, and population size.

The representatives of hospitals, nursing homes, and home health agencies and the discharge-planners and consumer advocates we met with had had as much as 9 months and as little as a few weeks of experience with PPS. We also talked with local health planners and representatives of peer-review organizations. Much of our information derives from the expectations that these people have based on their personal experience. In some instances, providers and local Medicare peer-review organizations were also able to provide us with data on changes in the use of long-term-care services after the introduction of PPS.

THE KEY ISSUES

Our key issues thus represent a distillation of the views of people working in different parts of the health care system at the federal, state, and local levels. Many of the same issues were raised in different forums by people representing different interests among providers and consumers living and working in different regions of the country. This reinforces our view that these issues are important.

1. Have Medicare patients' post-hospital needs changed? PPS creates strong incentives for hospitals to shorten patients' lengths of stay. In a December 1982 report to the Congress proposing a prospective payment system for Medicare, several

potential problems were discussed by HHS, including incentives in the system that could lead to the premature discharge of patients. We at GAO have raised similar concerns.[1]

Recent data on the use of hospitals under Medicare appear to show that hospitals have in fact responded by reducing lengths of stay. The average length of stay per PPS discharge in fiscal year 1984 was 7.5 days. The average length of stay per discharge in fiscal year 1983 (pre-PPS) was 9.5 days.[2] While reducing the length of a hospital stay may not affect a patient's need for follow-up care, it is also possible that some patients may be discharged at a time in their illness when they have substantial needs for care.

At each site we visited, the view was expressed in at least three groups among hospitals, nursing homes, and home health providers of care and advocates and discharge-planners that patients are being discharged from hospitals after shorter lengths of stay and in a poorer state of health than prior to PPS. In five of the sites, the issue of Medicare patients entering the various levels of post-hospital care (skilled nursing facilities, intermediate-care facilities, and home health) with more extensive service needs was raised in one or more of the meetings. Individuals in the four states with their own prospective payment systems also expressed the opinion that prospective payment may be associated with patients being discharged sooner and in poorer health. We were provided data by home health representatives in several communities showing more visits per case, more cases requiring multiple visits per week, and more need for specialized services such as I.V. therapy and catheters and ventilator care after the introduction of PPS.

2. How are patients' needs being met? To the extent that Medicare patients are discharged from hospitals sooner and with greater needs for care, PPS may increase the effective demand for the post-hospital nursing home and home health services covered by Medicare. HHS has predicted that the number of persons qualifying for the Medicare skilled nursing home benefit will increase. However, the Department's analyses indicate that a

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[1] GAO Staff Views on the President's Fiscal Year 1984 Budget Proposals, GAO/OPP-83-1 (Washington, D.C.: March 4, 1983), pp. 69-72.

[2] The data for fiscal year 1984 are based on monthly billing data that have not been adjusted to reflect the geographic distribution of hospitals that began to implement PPS during the year or the slow reporting of complex hospital stay records. See "Report on PPS Monitoring Activities," Health Care Financing Administration memorandum, January 20, 1985, p. 4.

marked increase in the use of skilled nursing facilities may be precluded by such factors as the shortage of nursing home beds and the importance that state Medicaid reimbursement policies have in determining nursing homes' willingness to accept Medicare patients requiring skilled care.[3]

What we were told at our site visits was consistent with this HHS analysis. In meetings at the three sites where the beds in skilled nursing facilities are very scarce, the view was expressed that any increase in Medicare skilled nursing home placements may be effectively precluded. However, in the one site with a relatively large supply of unoccupied nursing home beds, we were told that some increase in Medicare skilled nursing home placements was anticipated.

Attributing increases in home health placements to PPS may be difficult. Medicare is the major buyer of home health services, and the program's expenditures for home health services were increasing rapidly before the introduction of PPS. Between 1969 and 1980, Medicare home health expenditures grew at an average annual rate of 21.4 percent.[4] The Congressional Budget Office has projected 20-percent annual increases in Medicare home health costs for 1985-89.[5] Determining the incremental effects of PPS on an already rapidly expanding service will involve fairly complex analysis.

We were told in meetings of home health care providers at five of the six sites that discharges of hospital patients to home health services covered by Medicare had increased, both as a result of a trend toward greater use of home health services that began before the introduction of PPS and because of incentives created by PPS to discharge patients from the hospital more quickly. In the sixth site, where average length of stay has been traditionally lower than in most of the rest of the nation, we were told in meetings with representatives of both hospitals and home health care agencies that there do not appear to be increased discharges to home health care.

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[3] HHS, Report to Congress: Study of the Skilled Nursing Facility Benefit Under Medicare (Washington, D.C.: January, 1985).

[4] Health Care Financing Administration, The Medicare and Medicaid Data Book, 1983 (Baltimore, Md.: 1983), p. 38.

[5] Congressional Budget Office, Reducing the Deficit: Spending and Revenue Options, part 3 (Washington, D.C.: February 1984), p. 73.

However, evidence of a trend toward increased use of home health services may not be showing up on early reports of the use of Medicare home health services that are based on hospitals' discharge data. At two sites, we compared hospital discharge data from peer-review organization files with data provided to us by hospital discharge-planners. A large proportion (in one hospital, 89 percent) of monthly hospital referrals to home health care were not showing up as discharges to home health care on the hospital discharge abstracts processed by the peer-review organizations.

3. Are patients having access problems? Medicare's skilled nursing facility benefit covers only skilled care and provides full payment for only the first 20 days of care. A $50 per day copayment applies from the 21st day to the 100th day, after which coverage ends. GAO has found that some nursing homes may prefer to avoid accepting Medicare patients who might become eligible for Medicaid after exhausting their Medicare benefits. This is because Medicaid reimbursement rates for skilled care are not always sufficient to cover the costs of skilled care for Medicaid patients.[6] GAO has also documented similar problems of access to nursing homes for patients whose service needs are extensive, the so-called "heavy care" patients. PPS may unintentionally increase the problems of Medicaid patients who are waiting in hospitals for nursing home beds.[7]

At each site we visited, problems of access were raised in meetings with health care providers or advocates for the elderly. Problems associated with arranging placements for patients who depend on Medicaid for reimbursement and those who require "heavy care" or the use of sophisticated "high-technology" services were mentioned. However, at two sites we were told in meetings with nursing home administrators that patients who need extensive care and can afford to pay private skilled nursing facility rates do not necessarily have the problem of finding nursing home beds that patients eligible for Medicaid do.

The combination of PPS incentives for hospitals to discharge Medicare patients as soon as possible and weak incentives for nursing homes to admit some of them leads to the possibility of some inappropriate placements. Before the introduction of PPS, some patients who could not be placed in appropriate skilled-level beds remained in hospitals for considerable periods of time as so-called "back-up" patients. PPS provides stronger incentives for hospitals to discharge these patients. At several sites, we heard considerable speculation about what is going to happen to hospitalized Medicare patients who are difficult to place in appropriate long-term-care settings.

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[6] Improved Administration Could Reduce the Costs of Ohio's Medicaid Program, GAO/HRD-79-98 (Washington, D.C.: October 23, 1979), pp. 129-37.

[7] Medicaid and Nursing Home Care: Cost Increases and the Need for Services Are Creating Problems for the States and the Elderly, GAO/IPE-84-1 (Washington, D.C.: October 21, 1983), pp. 107-27.

4. How have long-term-care costs been affected? If the introduction of PPS leads directly to a greater use of the nonhospital services that Medicare covers, including those provided by skilled nursing facilities and home health care agencies, the costs of these services will increase and thereby affect overall Medicare costs. There may be other effects on costs as well. For example, GAO has found that the use of home health care services may not be cost-effective for certain types of patients, compared to either nursing home care or hospital care.[8] Increases in the number of skilled staff employed by nursing homes and home health agencies to care for sicker patients may also mean increased costs for Medicare services.

If Medicare beneficiaries make greater use of various post-hospital services, the costs of other federally funded programs, particularly Medicaid, and of state-supported programs, insurers, and private payers may increase. Any increased use of Medicaid skilled-care or intermediate-care beds by post-hospital Medicare beneficiaries could increase the costs of the Medicaid program. In meetings with advocates for the care of the elderly and discharge-planners in four sites, the possibility was also raised that out-of-pocket expenses for post-hospital care for beneficiaries and their families will increase.

LONG-TERM-CARE COMMUNITY CONCERNS

We were told in site meetings with providers and advocates that beneficiaries are upset and confused about their Medicare benefits and how PPS has affected them. We heard reports that some patients are being told, improperly, that they have to leave the hospital because their Medicare coverage has run out. We also heard that they sometimes do not understand why they are denied coverage for home health care or skilled nursing facility care. If problems such as these are in fact widespread, better education is needed for beneficiaries and providers.

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[8] The Elderly Should Benefit from Expanded Home Health Care but Increasing These Services Will Not Insure Cost Reductions, GAO/IPE-83-1 (Washington, D.C.: December 7, 1982), pp. 26-28.

In many of our site meetings with nursing home and home health providers, the view was expressed that Medicare was not making appropriate adjustments to coverage rules or reimbursement amounts in response to the perceived changes in the needs of the patients. In meetings with nursing home representatives at five of the six sites, we heard that Medicare and Medicaid reimbursement for skilled nursing home care does not meet the needs of some post-hospital patients. In all six sites, the view was expressed in meetings with home health representatives that either the restrictions of the rules on coverage or variations in fiscal-intermediary determinations of coverage created problems for discharged Medicare patients.

As we have reported in the past, some problems with coverage and eligibility determinations, particularly for home health services, reflect a lack of clarity in the Medicare regulations. We have found that under consistent application of those regulations, a fairly high proportion (27 percent in a 1981 study) of home health claims paid by Medicare do not meet program requirements for coverage.[9] More consistent enforcement of Medicare requirements may lead to more claims being denied, since changes in the administration of the home health benefit have been made to address the problems identified in our earlier report.

CONCLUDING OBSERVATIONS

We believe that the issues discussed in this report are sufficiently important to warrant HHS studies that will assess problems in access to and quality of post-hospital services supported by Medicare. In addition, we believe that studies should be done to analyze changes in long-term care and the total health care costs that are associated with PPS.

Because of variation in regional and local conditions, we believe that the extent to which the issues we have raised become serious problems may vary considerably. Differences in state and local long-term-care policy and in market conditions that shape demand and supply and the cost of post-hospital long-term care should be specifically addressed in the design of planned studies of PPS impacts.

As we indicated earlier, we are currently completing our work on our second objective, which is to review the data collection and analysis under way or planned at HHS for addressing the key issues and determining whether additional work needs to be done to insure that valid information will be available in a timely manner.

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[9] Medicare Home Health Services: A Difficult Program to Control, GAO/HRD-81-155 (Washington, D.C.: September 25, 1981), pp. 10-17.

As stated in your request, your urgent need for this preliminary report precluded us from obtaining agency comments. We will obtain advance review and ask for comments from HHS on our final report. Unless you publicly announce its contents earlier, we will make no further distribution of this report for 7 days. At that time, we will send copies to those who are interested and will make copies available to others on request.

Sincerely yours,

Eleanor Chelimsky

Eleanor Chelimsky
Director

Medicare	**Peer Review Organization Manual** INTERIM MANUAL INSTRUCTION	**Department of Health and Human Services** **Health Care Financing Administration**
Transmittal No. IM 85 - 2		**Date** MARCH 1985

NEW MATERIAL	PAGE NO.	REPLACED PAGES
Table of Contents	(5 pp.)	----
Chapter 2 Sec. IM 2000 - IM 2070	(62 pp.)	----
Attachment A-1	(1 p.)	----

NEW PROCEDURES - EFFECTIVE DATE: MARCH 25, 1985

In accordance with the PRO contract, Article VIII - Technical Direction and Article IX - Conditions of Performance, PROs are required to comply with requirements as set forth in program instructions. The HCFA Program Issuance System provides instructions and guidelines on program matters.

This issuance does not apply to PPS-exempt States or territories (i.e., Guam, Puerto Rico, or Virgin Islands) or to States with approved waivers of the PPS system, (i.e., Maryland, Massachusetts, New Jersey or New York). There will be a separate issuance for these States and territories delineating applicable sections of the requirements contained in this issuance.

This issuance incorporates the review procedures for the required medical review activities of the PRO contracts. There have been revisions to the required review activities - some of which increase the level of review, while others decrease workload. The major changes are:

Revision	Section
Admission Review - Incorporated policy applying to noncovered admissions with a covered level of care rendered during the stay.	IM 2050.1A.4
Outlier Review - Reduced the level of review for day and cost outlier cases. Expanded the cost outlier review instructions to require PROs to review for fragmented charges during review of outlier services/items.	IM 2050.2

[For brevity, only the Table of Contents of HCFA Transmittal No. IM 85-2 are incorporated in the hearing record.]

Procedure Review - Eliminated the requirement to collect pacemakers warranty information as the Food and Drug Administration now maintains a national registry on pacemakers.	IM 2050.3A
DRG Validation - Codified physician attestation policy (effective October 1, 1934) and monitoring requirements.	IM 2050.4A3
- Added section explaining physician requirements for physician attestation.	IM 2050.4A3a(3)
- Reduced DRG sample size for small hospitals.	Attachment A-1
- Revised policy on notifying hospitals of cases to be reviewed no more than 24 hours before onsite review. New policy requires notification 2 working days before onsite review.	IM 2050.4B5
- Added review of DRG adjustment bill which result in a higher-weighted DRG.	IM 2050.4E
Preadmission/Preprocedure Review - Explains the preadmission/preprocedure review and verification requirements.	IM 2050.5
Review for Noncovered Items/Services - Codified requirements for review for noncovered items/services during course of PRO reviews and of cases referred by fiscal intermediaries for medical necessity determinations.	IM 2060
Record of Review Activities - Outlines documentation and retention of record requirements.	IM 2070

The above summary outlines only major revisions. The attached section contains many clarifications and explanations of the review procedures in response to comments from PROs and other organizations. This revision should therefore be reviewed in its entirety.

Workload and Cost

The attached transmittal does affect the level of effort and cost required under the contract. The net result of these changes is estimated to be a 5% reduction in total workload/cost over the remainder of the contract period.

We do, however, recognize that the impact of this transmittal may vary in individual areas.

PEER REVIEW ORGANIZATION MANUAL
CHAPTER 2

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Sampling and Universe Review Instruction A-1

0343

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William E. Clark, Jr., M.D.
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Vice-President

Robert Takach, M.D.
Secretary-Treasurer

March 5, 1985

HSQB: ACTION
CC: Spiegel; Grief; REG. I

DIECT REPLY
DUE 4/2

Carolyne K. Davis, R.N., Ph.D.
Administrator of HCFA
Hubert H. Humphrey Building
314 G. 200 Independence Avenue S.W.
Washington, D.C. 20201

Dear Ms. Davis,

I am writing you regarding the current PRO regulations as they apply to the State of Maine. Dr. Craig Young and I met with Senator David Durenberger concerning the potential problems that the new regulations could impose upon patient care.

It is not a matter of whether surgery should be done as an inpatient or an outpatient, but rather whether we are being denied the right to use good clinical judgement. I feel very strongly that these arbitrary standards should be reexamined so that the patient does not have to suffer unnecessary complications. We are interested in cost containment of medical care, but not at the price of jeopardizing patient care.

Thank you very much for your concern in this very important matter.

Sincerely,

William E Clark Jr MD
WILLIAM E. CLARK, JR., M.D.

WEC:nr

Encls

HCFA/EXEC.SEC.
'85 MAR 11 PM 2:25

March 6, 1985

To: Cathleen McCarthy, PSRO, HSQB, HCFA
From: Mark Battista MD, Regional Medical Consultant, HCFA
Re: Draft of CPRO's Quality Objective "Reduction of the risk of preventable mortality from trauma"

---

1. The criterion for case review is death within 30 days of admission to hospital of a Medicare beneficiary for treatment of (external) trauma. This reasonable approach should capture a major portion of all trauma-related deaths in which some medical intervention was possible or attempted.

2. The proposed review of certain pre-hospital trauma deaths will provide useful information and seems very worthwhile.

3. The proposed expansion of review activities to include review of patients with similar injuries discharged alive, if certain patterns of inadequate care are identified in the primary review, would be very useful. Not only would this broaden the scope and the reach of intervention but might also provide helpful baseline data for subsequent potential objectives.

4. The establishment of the proposed Trauma Death Registry should be encouraged.

5. The chart review process and the trauma death review form seem well thought out and have some nice built-in validation features.

6. The PRO's initiative with regard to autopsy information is worthwhile.

7. The interventions proposed seem reasonable. The development of a consultant panel to impact on-going care to Medicare trauma patients is innovative, and the PRO should be encouraged to request the panel members to document at least generically the number and nature of requests for their input, and the nature and extent of their input. The proposed review (as needed) of a hospital's trauma care resources also has considerable merit.

8. The PRO, in Table 1, indicates that the projected 2 year total number of trauma deaths subject to review is 688, and of these, that 120, or 17.4% would be preventable. This percentage seems reasonable, given that it is within 2 percentage points of the percentage of preventable deaths among all "over age 65" trauma deaths in the two (combined) studies presented.

Thus, if all preventable deaths were prevented, the total number of trauma deaths would be 568 instead of 688. With the proposed

CPRO intervention, the PRO expects to be able to prevent 32 of those 120 preventable deaths (26.7%). Given the nature of the proposed interventions, and the nature of the problem itself, this seems a reasonable target at this time.

Conclusion: Overall, this objective is highly innovative and well thought out. It rests on and is consistent with data from two extensive local, on-point studies. Its proposed phase-in and ~~impact~~ schedule seems reasonable. The PRO obviously has broad-based support from the medical community and extensive expertise to help it fulfil the objective.

DRAFT

REDUCTION OF THE RISK OF PREVENTABLE MORTALITY FROM TRAUMA

OBJECTIVE: To reduce by 50% by the end of the contract period the risk of preventable mortality for Medicare patients admitted to the hospital for trauma

PROBLEM IDENTIFICATION, VERIFICATION, AND VALIDATION

Death resulting from trauma was the topic of two recent retrospective studies completed in Connecticut. The two studies combined included cases from twenty-three (23) of the thirty-five (35) acute care general hospitals in the state. Both studies identified patients admitted to the hospital for trauma who subsequently died and whose deaths could have been prevented. The conclusion from both studies was that aggressive evaluation and treatment of the patient's condition would result in the prevention of deaths of trauma patients.

The first study was conducted by the Interhospital Trauma Services Committee (composed predominantly of physicians) of the Capital Area Health Consortium. With the cooperation of the Hartford County PSRO, The Hartford County Health Care Plan and area hospitals, data were analyzed from 6,405 patients (1,647, or 26% of whom were Medicare patients) who were transported to one of the nine Consortium Connecticut hospitals because of injury during 1981. Through physician analysis and supplemental information from emergency room data, 177 (2.8%) trauma-related deaths were identified. Of these 177 patients, over 50% (89 of 177) were Medicare patients over age 65. A further breakdown of age groups showed that over 10% of the patients (18 of 177) were 65 to 74 years of age, while over 40% (71 of 177) were 75 years and older. This age distribution as well as the type of injuries, e.g., fractures resulting from falls, were much different from the trauma profiles commonly found in the literature.

Following data analysis, physicians reviewed the charts for all of the 177 trauma victims. A uniform approach to evaluating each case was used by the physicians to determine whether the deaths were preventable or not. A review instrument was used to abstract the pertinent details for each case which were then considered by the physician. The results of the individual physician reviews were then discussed by the Trauma Services Committee where final determinations were made. Through this method of study, 15 (8.5%) deaths were judged to be preventable: 7 were determined to be clearly preventable and 8 were possibly preventable. Of these 15 patients, 10 were Medicare patients 65 years or older. Of these 10 Medicare deaths, 4 were judged to be clearly preventable; the remaining six, possibly preventable. For the Medicare age group, this showed an overall rate of preventable deaths of approximately 11%.

The study evaluated preventability in terms of hospital care. The deaths which were judged to have been preventable were ones involving inadequate evaluation or treatment of the patient's condition so that there were undetected or untreated problems which caused the patient's demise. For example, these deaths involved a missed subdural hematoma, a missed diagnosis of chest bleeding, improper timing of a surgical procedure leading to a cardiac arrest, a technically inappropriate procedure for a patient with chest trauma. Each of these deaths could have been prevented with the use of a systematic approach to the care of the trauma patient which consists of: a rapid primary evaluation, resuscitation of vital functions, a more detailed secondary assessment and the initiation of definitive care. In all 15 cases an error or delay in diagnosis or treatment was made which directly contributed to or caused their deaths.

The second study, conducted by the Connecticut Society of American Board Surgeons and coordinated by Dr. Christopher Baker from Yale-New Haven Hospital, included data from twenty Connecticut hospitals for July 1983 through June 1984, (some hospitals were involved in both projects). This study included 2,557 patients age 65 or older, who were admitted to the hospital for trauma. Eighty-three (3.2%) of these patients died. The types and frequencies of diagnoses for all patients studied and those who died were similar to those within the Medicare age group identified in the Consortium study.

Each hospital participating in the study reviewed the medical records for all patients, with specific review for those patients who died to determine whether or not the deaths were preventable. Each hospital established its own guidelines for this decision-making process. In total, the review results identified 24 of the 83 deaths (29%) as possibly preventable. One of the conclusions of the study was, "The elderly should be targeted as a high risk group following trauma and should receive aggressive in-hospital care and outpatient rehabilitation to prevent mortality and morbidity respectively."

CPRO physicians believe that the risk of mortality for Medicare trauma patients could be reduced by improving the evaluation and treatment of these patients. At the beginning of its contract period, CPRO established a Trauma Steering

Committee to define and implement such a project. The membership of the Committee includes physicians throughout the state who are recognized as experts in trauma and/or surgery and non-physicians who represent other components of the Emergency Medical System. Exhibit A lists the members of this Committee and their affiliations. The Committee used as the basis for the project design the studies described above and other similar reviews performed in Connecticut and other states. It also identified two related areas for action by CPRO which it believed would impact positively on the basic objective.

First, the Committee agreed that the project should include Medicare patients who died from trauma prior to admission to the hospital and who received any treatment by personnel recognized as being components of the organized Emergency Medical Services System. As aggregated data are not currently available on these patients, it is proposed that CPRO initiate such data collection, along with the collection of data on inpatient deaths, through the establishment of a Trauma Death Registry and a review and analysis of the ER records and ambulance run-sheets for such patients. The Committee believes that the analysis of such information will permit the identification of actions which can be taken to reduce the mortality rate of these Medicare patients in addition to other planned interventions aimed at the inpatient deaths.

Second, the Committee identified the lack of autopsy information as a limiting factor to the complete evaluation of trauma deaths. The lack of information is the result of both difficulty in getting copies of reports when autopsies have been performed, and also the fact that autopsies are not routinely performed on such patients. CPRO Committee members have initiated discussions on these two areas with the Chief Medical Examiner of the State of Connecticut. Agreement has been reached that autopsy reports will be made available upon submission of a letter from the Steering Committee requesting the report. The Committee is still investigating the second aspect of the problem (the low proportion of cases that are autopsied) and determining what actions will be most appropriate to overcome this.

The Steering Committee has also initiated chart review activities on Medicare patients admitted to Connecticut hospitals for trauma who died within 30 days of admission and whose deaths occurred between October 1, 1983 and September 30,

1984. This review, which has followed the same protocol as described in the "Methodology" section on the following pages, has been completed for 34 charts through the step of referral to the full Review Committee for final determination as to preventability. Of the 34 cases reviewed, six (17.6%) were categorized as preventable by both the individual physician reviewers and the subcommittee of reviewers and were therefore referred to the full Committee. Exhibit B provides information on each of the six cases and the reason the death was categorized as preventable by the subcommittee. This finding provides further support for the results and conclusions of the other studies.

Based on the Committee's discussions and conclusions, a review of the previous studies, and the chart review activities initiated, CPRO proposes an objective to reduce the risk of mortality for Medicare patients suffering from trauma, that will encompass both inpatients and trauma patients who die in the ER. CPRO will also work toward the long term goal of increasing the frequency of autopsies on trauma victims.

BASELINE DATA AND PROJECTED IMPACT

CPRO physicians believe that through appropriate intervention methods, the risk of preventable mortality for Medicare patients suffering from trauma can be reduced. Although it is believed that this risk can be reduced through interventions aimed at both inpatient and pre-hospital services, data are only available at this point on inpatients. Consequently, CPRO's reduction objective is stated only in terms of these inpatients. It anticipates, however, that after review activities are initiated on the deaths of Medicare trauma patients that occur prior to admission, a supplement to this objective can be developed pertaining to the ER deaths.

CPRO proposes to reduce by 50% by the end of the contract period the risk of preventable mortality for Medicare patients admitted to Connecticut hospitals for trauma. As displayed in Table 1, achievement of impact will be graduated, with no impact expected until the third contract quarter and the full 50% reduction achieved by the second quarter of the second year. This will result in a cumulative reduction in the number of Medicare patients over the two year period with preventable deaths following admission for trauma from 120 to 88.

The baseline data for Medicare trauma patients and trauma deaths which CPRO is

TABLE 1

REDUCTION OF THE RISK OF PREVENTABLE MORTALITY FROM TRAUMA

BASELINE DATA AND PROJECTED IMPACT

		PROJECTED VOLUME & IMPACT*										
	BASELINE*	1st YEAR BY QUARTER				TOTAL	2nd YEAR BY QUARTER				TOTAL	2 YEAR TOTAL
		1	2	3	4		1	2	3	4		
Cases subject to the problem												
# of Medicare admissions for trauma	6,094	1548	1562	1575	1588	6277	1598	1609	1622	1636	6465	12,742
# of trauma deaths	329	84	84	85	86	339	86	87	88	88	349	688
Cases with problem												
# of preventable deaths without CPRO intervention	58	15	15	15	15	60	15	15	15	15	60	120
Cases with problem												
# of preventable deaths with CPRO intervention	n/a	15	15	13	12	55	10	8	8	7	33	88
Impact achieved												
Reduction in preventable deaths	n/a	n/a	0	2	3	5	5	7	7	8	27	

using for this objective, as displayed in Table 1, were developed from the study performed by the Capitol Area Health Consortium, as this study utilized the same definition of trauma patients proposed by CPRO. The data from this study were extrapolated to the rest of the state. The proportion of deaths identified as preventable was based on the recent chart review performed by CPRO which indicated that 17.6% of the inpatient deaths are preventable.

CPRO will refine these baseline data through continued chart review for each hospital in the state, and through data analysis when historical data for all hospitals are available.

METHODOLOGY

The following pages outline the approach CPRO proposes to accomplish this objective, including the establishment of a Trauma Death Registry. the evaluation of treatment for both inpatients and ER deaths, and the intervention steps to be taken.

Criteria

For the inpatient records to be reviewed, CPRO physicians feel that the most effective review method will be one conducted by physicians who specialize in the treatment of trauma patients. Therefore, physician specialists will review each of the charts for patients who die within thirty days of admission to the hospital for trauma to assess the clinical aspects of each case, together with the clinical management. An abstract of each case will be completed by a nurse reviewer prior to physician review. Exhibit C presents the draft of the instrument being tested in this process. Because all cases will involve physician review, explicit criteria for use by non-physician reviewers as a screening tool to eliminate cases from physician review will not be necessary.

For the review of Emergency Room deaths, CPRO's initial activities will involve: first, an analysis of the ER records and run sheets provided for these deaths to determine what information can be routinely and reliably collected from these documents; and, second, the review of this same material by physician reviewers for the purpose of the evaluation of the treatment given. Based on the results of these activities, CPRO anticipates that criteria or screens will be developed to be applied by non-physician reviewers to the information on these documents to identify cases requiring physician review of the treatment given.

Monitoring

The following protocol will be used by CPRO to monitor its progress toward achieving this objective and also continued compliance once the objective has been achieved. This review process will also guide the intervention activities.

1. Cases to be Reviewed:

The project will include those Medicare patients receiving treatment for injuries from external trauma. This will exclude internal injuries such as those caused by the ingestion of toxic substances.

All Medicare admissions to the state's general hospitals involving patients who die within 30 days of admission for such trauma* will be studied in terms of the hosptial care provided. Also reviewed will be deaths of trauma victims that occurred before admission to the hospital was possible but for whom treatment was provided by personnel recognized as being components of the organized Emergency Medical Services System. The Committee considered the inclusion of these emergency room deaths necessary in order to assess fully the medical intervention of trauma patients. Initial review of baseline data for inpatient deaths, including discharges prior to the effective date of the contract with HCFA, has been initiated. Subsequent review for both inpatient and ER deaths will include all Medicare trauma deaths occurring on or after the implementation date of the project.

To facilitate the review process and the aggregation and analysis of data on trauma deaths, a Trauma Death Registry will be established. An individual (preferably from the Medical Records Department) in each hospital will, on a weekly basis, identify Medicare trauma deaths occurring during the week and collect the information for the Registry for both inpatient and ER deaths and submit it to CPRO. Information to be collected will include: name; age; date of birth; sex; Medicare number; admit and discharges dates and medical record number for inpatients; and date of death for ER deaths. Cases to be reviewed as inpatient deaths will be identified from the Registry on an ongoing basis.

*For analysis of PATBILL data, this will include all cases with a LOS of 1-30 and a principal diagnosis in one of the following ranges: 800.00-839.9, 850.0-904.9 925-929.9, 940.0-957.9; 991.0-992.9.

Analysis of PATBILL data will confirm that all deaths have been so identified This method will provide for timely review of the inpatient deaths. The Registry will also be the sole source of data for identifying the ER deaths.

2. Chart Review Process

A. A complete copy of the medical record will be submitted to the CPRO office for all inpatient trauma deaths, including any pre-admission data that are available (e.g., ER records, run sheets). A letter requesting autopsy information will be sent as applicable on an individual case basis from the Steering Committee on Trauma to the Medical Examiner's office. A CPRO nurse will complete an abstract of the record (including the autopsy report if available). See attached Exhibit C for a copy of the review abstract. The abstract and the full record will be reviewed by a physician reviewer.

B. For the emergency room deaths, a copy of the ER record including any pre-hospital run forms, transfer forms, etc. will be submitted to the CPRO office on a weekly basis with the Trauma Death Registry submission. Data concerning the pre-hospital events surrounding the treatment of trauma patients in the pre-hospital environment will be accumulated by the CPRO staff. (See Exhibit D.) A physician reviewer will review these data and the associated documents to determine if there are any questions on the adequacy of the treatment given. It is expected that during the initial stages of the review of pre-hospital data and ED records, patterns of missing and inadequate data will be identified. Such patterns will also be recorded and analyzed for reporting back to the hospital and other parties as appropriate so steps can be taken to improve the recording process.

C. The physician reviewer will present each inpatient case s/he has reviewed (regardless of the conclusions of the review) to a subcommittee composed of four or five physician reviewers. In addition, the reviewer will present the ER deaths for which the management of the case was questioned. Those cases for which the subcommittee questioned the management of the case and determined the death to have been preventable will be referred to the full Committee of reviewers. This Committee will also review the case and make a determination concerning the case's management resulting in the categorization of the death as either preventable or not preventable.

For those cases categorized as preventable, a description of the case and the rationale for the Committee's determination will be sent to the hospital and the attending physician with a request that if either wishes to provide additional information on the case that such information be provided within two weeks. Any information provided will be reviewed by the full Committee. Following this review the Committee will make the final determination concerning the preventability of the case.

The full Committee will also review the aggregate statistics concerning ER deaths to identify any patterns in the management of cases which may represent problem areas. In addition, the Committee will use this statistical review to identify documentation problems for referral back to the appropriate parties.

The physician members of the Steering Committee will serve as the physician reviewers and as the members of the subcommittees and full committee for review. An individual physician reviewer will not review cases from his/her own hospital. The subcommitteeswill meet on an ongoing basis depending on the volume of cases for review. The full Committee will meet at least quarterly, and will meet more frequently if at any time the ongoing subcommittee review process has resulted in the identification of ten or more questioned cases for referral to the Committee.

Analysis of Review Results (Quarterly)

The Senior Quality Review Nurse assisted by the Data Analyst will, under the direction of the Trauma Steering Committee, prepare a quarterly report which will include a display of data and chart review results. The information will include aggregate data from the Trauma Death Registry and CPRO's data base on trauma deaths and trauma patients discharged alive, aggregate data from the review of records on ER deaths, and the physician review results from both inpatient and ER record review. The report will identify patterns by hospital and physician with respect to problems in case management. The report will be used by the Trauma Steering Committee in developing and/or modifying intervention activities (see below) and recommending specific actions to the CPRO Board of Directors.

Intervention

1. Initial Action

A. Notification of Objective to Hospitals and Physicians

The hospitals and all physicians in Connecticut have been notified that CPRO has an objective concerning the reduction of the risk of preventable mortality for trauma patients. Upon approval by HCFA of the objective, CPRO will notify the hospitals of the specific design of the objective, including the providers' responsibilities concerning the objective, the background information on the objective, the expected levels of impact, and the methods to be used to monitor compliance.

The letter, which will be directed to the Administration, the Quality Assurance Chairman, the Chief of Emergency Services, and the Chief of Surgery of each hospital, will also request that the aforementioned information relating to CPRO's objective be discussed at Departmental meetings, and,when possible, be included in one of the institution's publications. The hospital will be required to submit verification of this action to the CPRO Trauma Steering Committee.

In addition, CPRO will request that its representatives be afforded the opportunity to present information on the objective at the routine meetings of such groups as the CHA Committee of Directors of Emergency Departments, Committee of Hospital Administrators, Connecticut Emergency NursesAssociation, etc.

B. Reporting on Baseline Chart Review Results

Upon the completion of chart review activities for the baseline period for each hospital, a detailed report will be returned to the hospital on the results of this review, including specific recommendations for actions when indicated. In addition regional meetings for education purposes will be held with the Directors of the Emergency Room and other Departments and other appropriate staff (physician and non-physician) to discuss in detail the review results and the recommended modifications to the management of trauma cases.

C. Implementation of Consultant Panel

A panel of consultants will be developed who will be on call on a 24 hour basis to provide consultation services to the hospital for individual cases. The physicians will be on call on a rotating basis with two physicians on call at any given time, a primary contact and a back-up. The physicians on the panel will be recognized experts in Connecticut in the field of emergency services and surgery.

The panel will provide the means to affect directly on a concurrent basis the care given to Medicare patients suffering from trauma. It will provide access to all hospitals and physicians to specialist consultation during the decision-making process on the management of the patient. The use of the panel will be on a voluntary basis, unless review results have demonstrated over time that concurrent supervision of trauma management is necessary and no other supervision is available.

2. Ongoing Action

A. Dissemination of Review Results

The quarterly reports described above will be returned to the involved hospitals and physicians along with the Committee's conclusions concerning the reports. The parties involved will be required to respond to the findings in terms of steps taken to correct any deficiencies identified.

Summaries of the cases and the Committee's conclusions and recommendations will also be presented at regional meetings of the Directors of the Emergency and other Departments and other appropriate staff (physician and non-physician).

B. Availability of Consultants

The availability of the consultant panel described above will also be one of CPRO's ongoing intervention activities.

3. Additional actions

Additional actions will be taken as indicated by the results of the chart review activities. These actions may include but will not be limited to those described below. Some actions (such as a, b, and c below) may be implemented immediately upon completion of baseline data review or upon quarterly review results. Others (such as e and f) will be initiated if other attempts at corrective action have failed. Results of the actions will be assessed on a quarterly basis with the implementation of the successive actions (if needed) occurring immediately after the assessment. If improvement does not occur in response to the actions/recommendations over three successive quarters, sanc- will be initiated.

A. Review and Analysis of Hospital Trauma Care Resources

If chart review results so indicate, a review of a hospital's trauma care resources may be conducted to determine the availability and level of services for trauma victims. Recommendations for change will be made to the hospital as appropriate. The hospital will be required to report back what actions were taken in response to the recommendations.

B. Education sessions

Education sessions (in addition to the quarterly meetings) will be held when necessary on a hospital-wide basis or for groups of physicians, including residents treating trauma patients, that will involve a case study presentation of chart review results and indepth discussion of the systematic approach which should be used to evaluate trauma patients.

C. Expansion of chart review activities

If a pattern is detected in inadequate treatment of a specific type of injury or condition, chart review will be conducted on Medicare patients with similar injuries or conditions discharged alive. The results of this chart review will be used to further define the problem and identify an approach for corrective action for recommendation to the hospital. The hospital will be required to report back on actions taken as a result of the recommendations from this chart review.

D. Individual meetings/increased review for individual physicians

Should physician-specific patterns regarding problems in the management of trauma cases be identified, face-to-face meetings with the physician(s) and representatives of the Trauma Steering Committee will be held to reinforce the approach to the clinical evaluation of trauma patients. All Medicare trauma patients (i.e., deaths and all non-deaths) treated by the identified physician(s) in the subsequent quarter will be reviewed to determine whether the recommended clinical evaluation methods are being practiced.

E. Concurrent Supervision

Should other methods of intervention not succeed with an individual physician, the Committee may require that the hospital initiate direct concurrent supervision of the physician's treatment of Medicare trauma patients.

F. Sanctions

Should hospital or physician-specific problems in the management of Medicare trauma cases persist after other means of intervention have been implemented, sanctions will be recommended.

DEPARTMENT OF HEALTH & HUMAN SERVICES Office of Inspector General

Memorandum

Date MAR 1 3 1985

From Don Nicholson
Assistant Inspector General
for Health Financing Integrity

Subject Draft Peer Review Organization (PRO) Instructions on Unnecessary Readmissions and Transfers--INFORMATION

To Phil Nathanson
Director
Health Standards and Quality Bureau
Health Care Financing Administration

Thank you for providing us the opportunity to review the subject document. Your staff is to be congratulated for their efforts in addressing very complex issues.

We have the following specific comments on selected sections of the instructions:

1. IM 2086 PRO Interventions: In addition to the interventions listed in this section, PROs should also require hospitals to take the necessary action to prevent or correct the inappropriate practices. Nonconforming hospitals should be notified that continued abuse will lead to a sanction recommendation.

2. IM 2086A.2 Transfers: Parts (a), (b), and (c) of this section should be expanded to include denials of medically unnecessary, unreasonable, or inappropriate transfers to Prospective Payment System (PPS)-exempt Skilled Nursing Facilities including swing beds. We are aware of significant problems with transfers to swing beds in certain providers. This abuse must be addressed by the PROs.

3. IM 2086A.2.(c): Transfers from PPS hospitals to PPS-exempt rehabilitation units within the hospital should be included in this section.

4. IM 2086A.2.C.2.: This section is inconsistent with current guidelines in that it allows a Diagnostic Related Group payment for an acute care admission of a patient for whom a lower level of care was indicated. In this situation, it would be more appropriate to deny the admission to the acute, non-exempt part of the hospital and pay for the care in the exempt part.

5. IM 2086B.2.b.: We believe that this section, as written, may generate an excessive sanction workload for the PROs. Rather than specifying that two or three cases constitute a substantial number of cases, we recommend that this section be made compatible with the following definition from the PRO sanction regulation: "Substantial violation in a substantial number of cases" means a pattern of care has been provided that is inappropriate, unnecessary, or does not meet recognized professional standards of care, or is not supported by the necessary documentation of care as required by the PRO.

6. IM 2086E. Referrals of Office of Inspector General (OIG): This section should be modified to clarify that, in addition to referrals of sanction cases, PROs should also refer to the OIG those hospitals that demonstrate a pattern of inappropriate admissions and billing practices that have the effect of circumventing PPS. This distinction is important because PROs may identify patterns of abuse which are not related to unnecessary care, poor quality of care, or inadequate documentation.

7. The final page specifies three instances in which PROs should not deny readmissions or transfers. The first two instances are very prone to abuse and the draft instructions are too restrictive in that they do not allow the PRO to make any denials. We understand that HCFA expects to publish regulations which will change the method by which transfer cases between PPS hospitals are paid such that there will be one payment for the entire course of inpatient hospital treatment. Until such regulations are published, the instructions should be modified to allow the PROs to deny transfers which, in their judgment, are not compatible with locally acceptable patient care practices.

Finally, there are two additional issues which are not addressed in the instructions.

First, there have been over 2,000 cases referred by Medical Review Entities to HCFA regional offices in accordance with current instructions. In accordance with 42 CFR 405.472(e)(1), these cases should be reviewed by the PROs and the appropriate action taken.

Second, denials made according to the new instructions should be included on the monthly report of medical review activity.

If you or any member of your staff have any questions, please contact Barton McCann, M.D. on extension 70831.

OIG:OHFI:BMCCANN:ck: 03/08/85:PROHSQB,2,3
03/11/85:(typo corrections per Dr. Bart)

DEPARTMENT OF HEALTH AND HUMAN SERVICES

March 19, 1985

Larry Pitman
Executive Director
Kansas Foundation for Medical Care
2953 S.W. Wanamaker Drive
Topeka, Kansas 66614

Re: HCFA-500-84-0506

Dear Mr. Pitmam

You recently responded to our letter of January 7, 1985, which forwarded PRO Program Directive Number 5. It is your position that this directive added new responsibilities not included in your contract and you would not begin review until an official modification is made to your contract.

The terms of your contract stipulate in Article IX that "the contractor agrees to comply with the requirements of any changes in legislation, applicable regulations and program directives." If these changes cause an increase in cost, the Secretary is to be advised of the associated increased cost with justification for the need of additional funds to perform the review. However, you are required to initiate these changes in the timeframe specified by HCFA notwithstanding the absence of a modification to your contract.

If you have any questions, please contact me.

Sincerely yours,

Brenda F. Burton, Project Officer
Medical Review Branch
Division of Health Standards
and Quality

cc: Contract Office, HSQB
bcc: Lear/Burton
FILE: KS.2
HCFA:DHSQ:MRB:BFB:lsf:3/19/85:X5748

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OFFICE	SURNAME	DATE	OFFICE	SURNAME	DATE	OFFICE	SURNAME	DATE
	Burton	3/19/85						
	Lear	3/19/85						

DEPARTMENT OF HEALTH AND HUMAN SERVICES

March 27, 1985

Project Officer, Medical Review Branch
Division of Health Standards and Quality
Health Care Financing Administration - Kansas City

Contract Number 600-84-0513

Allan Lazar, Acting Director
Office of Medical Review
Health Standards and Quality Bureau
Health Care Financing Administration
Room 1-K-3, Dogwood East Building
6325 Security Boulevard
Baltimore, Maryland 21207

Attention: Cynthia Graunke

On February 5, 1985, the Iowa Foundation for Medical Care (IFMC) wrote to Burton Steckler expressing concern about additional work required to review DRG 462 cases and requesting funds for this activity. (Copy attached) The correspondence is being controlled as a pending contract modification.

It is my recommendation that this be disposed of by letter to IFMC indicating that the additional work created by review of DRG 462s has been offset by other review activity changes included in the recently issued Peer Review Organization Manual interim manual instruction 85-2. IFMC should be advised that if additional funds are required as a result of this manual issuance, a detailed request for funds explaining all changes in level of review activity should be submitted.

If further action on my part is needed, please let me know.

Benny G. Gruber

Attachment

cc: Burton Steckler, Contracts Office
Lear/Gruber

HCFA:DHSQ:MRB:BBURTON:ir

IA. 2

FILE COPY

OFFICE	SURNAME	DATE	OFFICE	SURNAME	DATE	OFFICE	SURNAME	DATE
MRB	[illegible]	3/28/85						
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DEPARTMENT OF HEALTH & HUMAN SERVICES

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MAR 27 1985

Director
Office of Medical Review

PRO Contract Workload

Associate Regional Administrator
Health Standards and Quality
Regions I - X

The Office of Medical Review has received several inquiries from PRO contractors regarding the possible increase in workload as a result of Program Directive #5 which requires review of DRG 462 cases. First, we must emphasize that under Article IX of their contract, PROs must comply with all changes in program policy and instruction. We are similarly obligated to negotiate changes in price as appropriate.

In this case, the slight increase in review activity will be offset by the decrease in workload as a result of modifications in APM and required medical review activities of the PRO. The instructions implementing these changes were issued as IM-85-2, as Interim Manual Instruction for the Peer Review Organization Manual dated March 1985. Revisions to the APM activities are scheduled to be issued soon. It should be noted that as of this time we have not released two quarters of APM activity, which in and of itself has significantly reduced the individual PROs workload and costs to date.

Any contractor that has failed to implement review of DRG 462 cases in accordance with Program Directive #5 is out of compliance with its contract and appropriate corrective action must be taken immediately. If a PRO can substantiate that the shift in workload creates an inequity, and additional funds are needed, the PRO should submit a budget with justification to its project officer.

Allan Lazar
Allan Lazar

ALABAMA QUALITY ASSURANCE FOUNDATION
SUITE 300, TWIN TOWERS EAST
236 GOODWIN CREST DRIVE
BIRMINGHAM, ALABAMA 35209
TELEPHONE (205) 942-0785

April 3, 1985

Mary Gregory, Project Officer
DHHS, Region IV
101 Marietta Street N.E.
Suite 502-A
Atlanta, Georgia 30323

Dear Mary:

Alabama Quality Assurance Foundation, as the PRO for Alabama, would like to propose a contract modification to address the need for effective, efficient utilization review and quality assurance for Medicare beneficiaries in long term care facilities in the state of Alabama.

A preliminary report by the General Accounting Office has stated that Medicare's prospective payment system may be forcing patients out of the hospital too soon and in poorer health than before PPS was in place. This means that Medicare skilled nursing facilities may be receiving Medicare patients who are requiring more services than the SNFs are experienced in providing. In some instances, Medicare patients may be subjected to substandard care causing readmission to the hospital after seven days. A comprehensive system to track patients discharged from acute care facilities to SNFs and back through subsequent readmissions to hospitals should be established to ensure that necessary, high quality care is provided to Medicare beneficiaries. Because SNFs are being paid to perform UR by Medicare, the cost of third party quality review would be offset by reductions in Medicare payments to the SNFs to perform their own UR.

Since 1980 at the Foundation, concern about quality and appropriateness of care has extended beyond the hospital to the long term care setting. Under the PSRO Grant of 1980-81, the Foundation conducted Medicare and Medicaid long term care review. This experience resulted in identifying quality of care problems as documented by audit findings and addressed in the attached proposal. Due to the PSRO Grant being defunded by the federal government for all PSROs having long term care grant funds, the Foundation was unable to determine if intervention was made to correct these problem areas.

Again in 1981, the Foundation, through long term care review for the State Medicaid Agency, noted quality of care problems in their review. Because in 1982, the State decided to reactivate its review program, the Foundation has been unable to determine if these problems have been addressed.

Mary Gregory
April 3, 1985
Page Two

Presently, under private review contracts, 24 nursing homes utilize the Foundation's expertise to assist in utilization review and quality assurance activities. As discussed in the attached proposal, demonstration of our effective utilization review is apparent with the average length of stay for the nursing homes reviewed by the Foundation to be 8.16 days, while FI statistics reveal an SNF length of stay to be 16.37 days.

The Foundation's experience in the utilization and quality assurance review process demonstrates our capability to assume expanded review functions for Medicare beneficiaries in long term care settings. Therefore, the Foundation recommends that HCFA consider revision of the Scope of Work for the PRO contract for Alabama Quality Assurance Foundation to include long term care review for Medicare beneficiaries.

Sincerely,
ALABAMA QUALITY ASSURANCE FOUNDATION

John W. Miller
Chief Executive Officer

Enclosures
/lh

cc: Phil Gomez/HCFA

ALABAMA QUALITY ASSURANCE FOUNDATION

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III. DATA PLAN

IV. FINANCIAL PLAN

SECTION I - PROBLEM PAPER

I. PURPOSE

To present information regarding the need for effective, efficient utilization review and quality assurance for Medicare beneficiaries in long term care facilities in the state of Alabama; and to propose a contract modification to address this need.

II. PROBLEMS

1. Long standing quality of care problems documented by audit findings.
2. Lack of a comprehensive system to track patients discharged from acute care facilities to SNF and back through subsequent readmissions to hospitals.
3. Increase in the need for skilled nursing care due to prospective payment incentives to discharge patients early. The PRO has no provisions to evaluate this area of premature discharge.
4. Pressure from State Medicaid officials to increase Medicare utilization of skilled days to effect a reduction in Medicaid utilization.
5. Medicare co-insurance payments exceed the average room rate in nursing facilities. Patients and families request patients be removed from Medicare past the 20th day of coverage creating an increased burden for Medicaid coverage.

III. BACKGROUND

1. Under the PSRO Grant of 1980/81, the Foundation conducted Medicare and Medicaid long term care review. Quality assurance studies conducted during that period included a comprehensive study of patients transferred from nursing homes to acute care facilities. The sample included 1,644 nursing home records from the 166 nursing homes in the State. Criteria for the study included evaluation of physician and nursing personnel activities prior to transfer. The following problems were identified:
   a. unavailability of attending physician when personnel required guidance regarding patient care problems;
   b. inadequate physician follow-up and treatment of existing or new problems;
   c. failure by the nursing staff to (1) check and record vital signs; (2) report active bleeding; (3) recognize and/or report indications of complications; (4) high incidence of fractures and other trauma; and (5) delays in transfer of acutely ill patients of up to three hours or more.

   The Foundation was in the process of completing this quality review study when the long term care portion of the PSRO Grant was defunded by the federal government for all PSROs who had long term care grant funds. No intervention has been made to correct these problem areas. The PPS pressure to discharge Medicare patients earlier and in poorer health may cause these already identified quality of care problems to intensify.

2. In 1981 the Foundation conducted long term care review for the State Medicaid Agency; however, in 1982 the State decided to do its own review. Close-out reports to the Medicaid Agency detailed the quality of care problems noted by the Foundation. We are unable to determine if these problems have been addressed in all of the State's SNFs.

3. Presently, under private review contracts, 24 nursing homes throughout the State utilize the Foundation's expertise to assist in utilization review and quality assurance activities. Problems noted in association with these contracts are (1) pressure from State Medicaid officials to increase Medicare utilization to effect a lesser burden on Medicare coverage; (2) increasing pressure to stop Medicare coverage on the 20th day from families and patients due to high co-insurance, which exceeds the average room rate; and (3) pressure from State licensure officials regarding quality review studies. The nature of that pressure suggests an apparent lack of understanding of the principles and objectives of quality review. At a recent meeting with the Foundation's Long Term Care Director and quality assurance staff, State licensure officials discussed documentation of quality review studies in UR minutes. The State indicated that once UR minutes reflected that data collection had been completed for a study, the minutes should address another area of quality review. From this perspective, analysis of data, conclusions and recommendations were "paper work". The Foundation's view is that a study is not complete until the UR Committee has addressed each component of a study. It is the Foundation's policy that quality review studies begin with identification of problems/topics and with follow-up action regarding any UR Committee recommendations.

4. Demonstration of the effective utilization review conducted by the Foundation is apparent in the comparison of the average length of stay for the 24 skilled nursing facilities the Foundation has under private review, with the average length of stay for the remaining facilities. Based upon 1984 4th quarter data, a sample of Medicare SNF admissions for the 24 homes reviewed by the Foundation revealed an average length of stay of 8.16 days, while FI statistics reveal an SNF length of stay, based on claims paid from July 1, 1984 through December 31, 1984, of 16.37 days. These statistics point out a liberal use of SNF days by those facilities conducting their own utilization review. In addition, our quality review program has addressed quality problems in these SNFs.

IV. DISCUSSION

1. PROs have been made responsible for quality assurance activities in acute care facilities. One of the quality objective areas common to all PROs is to reduce unnecessary hospital readmissions resulting from substandard care provided during the prior admission. Due to the fact that PROs do not have a mandate nor funds to conduct review of nursing home records, a significant group of patients discharged from acute care facilities are not evaluated for premature discharge. The liklihood of readmission to an acute care facility within the seven day readmit time parameter is diminished due to nursing homes financial incentive to retain patients and the inability of nursing home staff to recognize and report problems. It is also common knowledge that readmission within seven days comes under PRO review. This creates an incentive for the SNFs to keep patients over the seven day period to avoid review, when the patient's condition requires acute care in the hospital.

2. A preliminary report by the General Accounting Office (GAO) has stated that Medicare prospective payment system may be forcing patients out of the hospital too soon and in poorer health than before PPS was in place. The GAO found that skilled nursing facilities (SNFs) are treating sicker patients.[1]

3. In addition, a survey of State nursing home ombudsmen conducted by the House Aging Committee and its Task Force on the rural elderly found:
   - -77% of those responding said patients are being discharged sicker or much sicker than before PPS
   - -Over 71% indicated that more or many more people need skilled nursing care since PPS and over 50% stated that existing SNF carriers are inadequate to meet the needs of discharged hospital patients in rural areas. One-third said the care was inadequate in urban areas.
   - -59% stated that nursing homes did not have adequate personnel to provide care in rural areas before PPS and 67% believed this was true after PPS. In urban areas, the before and after change was 49% to 56%.[2]

4. The 1980-81 transfer study indicated that a high percentage of patients were transferred from nursing homes to acute care facilities when death was imminent. The incentive to increase this practice in PPS hospitals, especially for those who also own nursing facilities, is a real concern. Patients for whom death is but hours away are a source of possible revenue under PPS. Often coded as an MI, when in fact a multitude of diagnoses may be responsible for the admission and subsequent death, DRG reimbursement is high for these dying patients.

5. With the implementation of the UB82 for skilled nursing home Medicare billing on 3/1/85, the disposition codes will allow tracking and profiling of readmission of patients from SNF to acute care facilities. Data from hospital discharges regarding disposition is presently available.

6. Through the Acute Care Review Program, all Medicare patients are assessed on a pre-admission or concurrent basis as to the appropriateness of admission to an acute care facility. The readmission study conducted in 1980-81 revealed that of the 1,644 records reviewed, 96.5% of the patients met the criteria for admission to an acute care facility. As the pressure increases to discharge patients earlier from PPS hospitals to maximize reimbursement, SNFs have responded with the protest that they are ill equipped to care for these patients. Results of the transfer study validate this argument. It is inevitable that hospital admissions from SNFs will increase for two reasons: (1) premature discharge for reimbursement incentives; and (2) poor quality of care in SNFs.

7. Therefore, major aspects of quality of care assessments require review in the following areas:
   1. Evaluation of readiness for discharge from hospitals by evaluating SNF admissions from acute care facilities that result in readmission to an acute care facility within 14 days of hospital discharge.

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[1] Medical Utilization Review, February 28, 1985, Vol 13, No. 5, Pg. 4
[2] Medical Utilization Review, February 28, 1985, Vol 13, No. 5, Pg. 3

2. Reason for admission to hospital from SNF.
3. LOS information between SNF and acute care episodes. With the addition of the UB82 field, reasons for admission beginning with April 1985 cases can be cross-referenced from the acute and SNF facility PATBILL files.

Utilizing SNF as a point of patient origin, a statewide SNF hospital readmission data base can be created. Profiling would provide for analysis across provider units of the diagnosis on admission. By using the HIB number, the hospital PATBILL file can be accessed to link the two episodes and provide information regarding primary diagnosis. Length of stay at SNF between acute care episodes promises to be an important indicator of the ability of the skilled facility to care successfully for the patient and for evaluating premature discharge. Admissions to acute care facilities for fractures and trauma present an interesting profiling possibility when compared across SNF providers. Additionally, patients who expire 24, 48 and up to 72 hours after transfer from either hospital to SNF or SNF to hospital will yield valuable information.

V. RECOMMENDATION

That HCFA consider revision of the Scope of Work for the PRO contract for Alabama Quality Assurance Foundation to include long term care review for Medicare beneficiaries, as follows:

A. Admission Review:
   Prior approval of Medicare admissions to the 201 skilled nursing facilities in Alabama.

B. Continued Stay Review:
   Level of care review on or before the 8th, 15th and 21st day after admission and every 14 days until Title XVIII benefits are exhausted or until certification is denied, whichever comes first.

C. Monitoring Plan:
   Review Coordinator to monitor level of care on-site in the nursing homes on or before the 20th day past admission.

D. Quality of Care Review
   1. Ongoing: Conduct ongoing review of patients transferred from an acute care facility to SNF and subsequently readmitted to the hospital within 14 days of discharge to determine if the readmission resulted from substandard care/premature discharge from the prior hospital admission. Review to be conducted by physician members of the UR Committee.

      Conduct ongoing quality of care assessments of patients transferred between SNF and acute care facilities by utilizing quarterly statistics, as outlined in Section III of Data Plan, to identify quality of care concerns in the following areas:
      1. Death rate within 24, 48 and 72 hours of admission to nursing home;
      2. Death rate within 24, 48 and 72 hours of admission to hospital;
      3. Admission from SNF for fractures and other trauma; and
      4. Average length of stay between acute care facility stays at SNF.

   2. Focused Review: Based upon identification of problems by quarterly statistics, Utilization Review Committee will select area for intensified quality review study which will be conducted during the following quarter.

3. **Readmission Review:** Evaluation of readiness for discharge from hospitals by evaluating SNF admissions from acute care facilities that result in readmission to an acute care facility within 14 days of the hospital discharge. Material utilized in the readmission review is contained at Enclosure IV.

   Physician members of the Utilization Review/Quality Assurance Committees will conduct this review.

   Monitoring of premature discharge/substandard care will be conducted. Identified patterns of premature discharges will result in educational intervention efforts with the attending physician.

E. Take action to resolve quality of care problems
F. Report to HCFA on monthly transfers between SNFs and acute care facilities.
G. Report to HCFA on readmissions from SNF within 14 days of discharge from an acute care facility that resulted from premature discharge/substandard care from the initial hospital admission.
H. Report to HCFA on monthly number of SNF days used by facility.
I. Report to HCFA on monthly number of SNF admissions certified or denied.
J. Report to HCFA on monthly number of reconsiderations with UR Committee decision (proposed monthly reports are at Appendix A).

SECTION II
ALABAMA QUALITY ASSURANCE FOUNDATION
LONG TERM CARE UTILIZATION REVIEW PLAN FOR MEDICARE

ORGANIZATION AND COMPOSITION OF COMMITTEE

The twenty-five (25) member Board of Directors, consisting of physicians, hospital administrators and industry representatives, shall be responsible for the utilization review activities of the Alabama Quality Assurance Foundation. The Board shall delegate the responsibility for performing UR functions to the Long Term Care Committee, consisting of physicians appointed by the Medical Director, and to Physician Advisors and professional staff employed by the Foundation. Review by the Committee shall not be conducted by any person who is employed by the facility being reviewed or who is financially interested in any SNF, or by any person who is professionally involved in the care of a patient whose care is being reviewed.

FREQUENCY OF MEETINGS

The Long Term Care Committee shall meet at least every thirty (30) days. The Chairman of the Committee may call meetings during the interim period, if necessary. Physician members of the Long Term Care Committee shall be available to the Foundation Area Review Coordinators for consultation.

RECORDS

Minutes of each Committee meeting shall be recorded and maintained and shall include the following:

1. Name of Committee
2. Date of Meeting
3. Duration of Meeting
4. Names of Committee members present and absent
5. Names of staff present
6. Outline of activities
    a. MCE Studies
        (i) Subject
        (ii) Beginning and expected completion date
        (iii) Conclusion
        (iv) Recommendations of the Committee
        (v) Follow up on implementation of recommendations.

    b. Extended Stay Cases reviewed with summaries made of the dispositions. Copies of the general minutes and all pertinent report relating to the facility will be forwarded to the Administrator of the facility within fifteen (15) days following the meeting.

    Documentation of extended duration Medicare cases shall be given to the Administrator at the time of review and shall be maintained in the Medicare beneficiary's record within the facility.

    Documentation of action taken for each case not approved for continued care shall be in the form of an Initial Adverse Determination. A final determination by a physician member of the Committee or by the full Committee that admission or continued stay is not medically necessary is made by at least two physician members of the Committee except that the final determination may be made by one physician member where the attending physician, when given an opportunity to express his views, does not do so or does not contest the finding that the admission or continued stay is not medically necessary. Notification of an Adverse Determination shall be forwarded to the beneficiary and his/her representative, attending physician, facility and fiscal intermediary or State Medicaid Agency.

Documentation of UR activities as to the initial and subsequent continued stay reviews will also be maintained throughout the benefit period and for one year after audit by the fiscal intermediary, State Agency survey or other responsible audit agency.

REVIEWS
The continued stay of each eligible individual will be evaluated against written criteria developed by the UR Committee. Closer professional scrutiny will be applied in cases requiring continued stay and associated with high costs, excessive services, or if the attending physician's patterns of care are frequently found to be outside of established parameters.

I. Medicare

A. Pre-Admission Review

Pre-admission review (prior approval) [Enclosure I] for skilled care will be conducted for all Medicare beneficiaries prior to or on the day of the nursing home admission. The review is based on the attending physician's reasons for and plan of care for the admission to the facility. Cases will be screened by a qualified non-physician representative of the Committee (Review Coordinator) using criteria established by physician members of the Committee (Enclosure II). Cases that do not pass the screening criteria will be referred to a Physician Advisor for a determination. The Physician Advisor may contact the attending physician for additional medical information in cases that he is unable to approve. Based on all information available, the Physician Advisor approves or denies the admission to the facility. In cases of denial, written notification is provided to the facility, patient, patient representative and attending physician within 24 hours of the determination.

B. Continued Stay Review (Extended Stay Review)

The First continued stay review will be conducted on or before the 8th day of admission. The review is based on the attending physician's reasons for and plan for continued stay and other documentation the Committee deems appropriate. Cases will be screened by a qualified non-physician representative of the Committee (Review Coordinator) using criteria established by physician members of the Committee. Cases are referred to a Physician Advisor if it appears skilled care is no longer necessary.

Where a finding is made that the individual continues to need inpatient skilled nursing care, an additional stay not to exceed days up to the 20 day period is approved. Before the expiration of each new period, the case must be reviewed again in like manner. Where a finding is made that the individual does not require inpatient skilled nursing care, the attending physician will be contacted by a member of the Committee. Opportunity is extended for the attending physician to provide additional medical information. Verbal notification is made the same day to the facility. Written notification of the Physician Advisor decision will be made within twenty-four (24) hours of the determination to the facility, attending physician, patient and patient representative [Enclosure III]. It is the responsibility of the facility to notify the appropriate fiscal agent.

Continued stay reviews will be conducted at least every fourteen (14) days throughout the 20 day day post acute benefit period or until Title XVIII benefits are exhausted or until certification is denied, whichever comes first.

MEDICAL CARE EVALUATIONS

Purpose: To promote the most effective and efficient use of all available health facilities and service consistent with patient needs and professionally recognized standards of health care.

A minimum of one (1) Medical Care Evaluation will be conducted in the skilled nursing facility annually. The period of evaluation is considered to be twelve (12) months following the implementation of the UR Plan. One (1) study will be in progress at any given time.

The study(s) will be conducted on a subject(s) recommended by the Committee, based on data obtained through ongoing quality of care assessments i.e., readmissions, deaths, trauma) and identification of problems unique to the level of care and/or patient population.

Criteria, guidelines and time frames will be developed by the committee to facilitate the study. The Administrator will receive notification of the study(s) through minutes of the Long Term Care Committee meetings. When the study(s) is completed, an analysis will be made of data collected and recommendations will be made to the Administrator as to the avenues for corrective action and/or recommendations of the Committee.

A plan for implementation of Committee recommendations and/or an alternate method to achieve the intent of the recommendations is to be provided to the Committee within thirty (30) days from the date of the notification. The facility implementation plan is to include anticipated date of full implementation.

RECONSIDERATIONS

Reconsiderations will be held at the Foundation's Central Office, utilizing two (2) physicians other than the one making the initial determination.

NURSING HOME RESPONSIBILITIES

The nursing homes would be responsible for calling in all admissions eligible for Medicare coverage on or before the day of admission. The nursing homes will be responsible for verifying the eligibility of Medicare recipients and the days available to that patient before calling for prior approval.

ENCLOSURE I

PRIOR APPROVAL ASSESSMENT

Date:____________________ 19____ Contact:____________________

Facility____________________ Medicare #:____________ Certified:____

Patient Name:____________________ DOB:________ Medicaid #:____________

From:____________________ Prior Control #:__________ LOC:____

Attending/Referring M.D.:____________________ Admission Date:__________

MEDICAL INFORMATION

DIAGNOSIS:____

____ Bedfast

____ Bedchair Fast

____ Walks with Help

____ Walks Alone/with Device

____ NG Tube/Gastrostomy

____ Has to be Fed

____ Feeds Self

____ Foley/Condom

____ Ileostomy/Colostomy

____ Incontinent

____ Decubitus/Other Skin Problems

____ Traction

____ Cast

____ Terminal Illness

____ Assist with A.D.L.

Speech__________ Hearing__________

Sight________ Mental Status__________

MEDICATIONS:____________________

____

____

____

____

TREATMENTS:____________________

____

____

____

THERAPY:____________________

____

____

____

COMMENTS:____

____

Certified For:____________________(Medicare Number of Days)

____________________ Medicaid Level of Care

P.A.__________________ Denied:________ Reason:__________________

____

PRIOR APPROVAL COORDINATOR:________________________________

ENCLOSURE II

Level of Care Criteria

SKILLED CARE

Level of Care Determinations:

Guidelines for Skilled Care:

The principal aspect of covered care relates the skilled services being rendered. The controlling factor in determining whether a person is receiving covered care is the level of care and medical supervision that the patient requires.

An individual is eligible for extended care benefits under the following circumstances:

1. Skilled nursing care, or other skilled rehabilitation service, is required on a daily basis;
2. For further treatment of any condition for which inpatient hospital services were received.
3. For a condition arising while in a skilled nursing facility receiving care for a condition for which inpatient hospital services were received; and - as a practical matter, can only be provided in a skilled nursing facility on an inpatient basis.

A skilled nursing service is one which must be furnished by, or under the general supervision of, a registered nurse and under the general direction of a physician.

Specific Services Which are Skilled:

Those which the patient requires on a regular basis including, but not limited to, the following:

1. Administration of a potent and dangerous injectable medications and intravenous medications and solutions.
2. Restorative nursing procedures; such as gait training, bowel and bladder training - in the case of patients who are determined to have restorative potential and can benefit from the training.
3. Nasopharyngeal aspiration required for the maintenance of a clear airway.
4. Maintenance of tracheostomy, gastrostomy, and other tubes indwelling in body cavities as an adjunct to active treatment or rehabilitation of a disease for which the stoma was created.
5. Administration of tube feedings.
6. Administration of oxygen or other medicinal gases on a regular or continuing basis in the presence of an unstable medical condition.
7. Care of extensive decubitus ulcers or other widespread skin disorders.
8. Insertion, sterile irrigations, and replacement of catheters.
9. *Application of dressing involving prescription medications and asceptic techniques.
10. Other specified and individually justified services, including skilled nursing observation of unstable medical conditions required on a regular and continuing basis which can only be provided by, or under the direction of a registered nurse.

ENCLOSURE III

MEDICARE DENIAL LETTER

PATIENT:

FACILITY:

MEDICARE NUMBER:

DATE:

As a part of Medicare regulations, it is a requirement that the beneficiary (patient) and/or his/her representative be advised in writing when the services needed by the patient do not meet the criteria for coverage under the Medicare program. In accordance with this, we wish to advise as follows:

_____1. The information available at the time of, or prior to admission shows that the specific medical services to be furnished do not meet the requirements for coverage under Medicare.

However, should you request the facility to file a claim with Medicare, you will receive a formal determination from the Medicare intermediary as to the non-coverage of the stay.

_____2. The specific service furnished no longer qualify as covered under Medicare beginning________________________. The Medicare intermediary will send you a formal determination as to the non-coverage of this stay.

This Medicare notice does not mean that you must leave the facility. Payments for your continued stay on the date given above will be your responsibility or, if you are eligible, paid by the State Medicaid program. You have the right to a reconsideration of this decision. If you have any questions or would like to request a reconsideration, please call us at (205)942-0785 or 1-800-554-5946.

Sincerely,
ALABAMA QUALITY ASSURANCE FOUNDATION

Director of Long Term Care

cc: Patient Representative
Facility
Attending Physician

ENCLOSURE IV

READMISSION REVIEW________

HIB#________ DATE TO COMMITTEE:________ MR #________

1st Admit Date:________ HOSPITAL:________
Attending Physician:________ Surgeon:________
2nd Admit Date:________ HOSPITAL:________
Attending Physician:________ Surgeon:________

QUESTION	YES	NO	EXPLANATION
1. Was complaint for which patient 1st admit thoroughly investigated & documented (H&P, PN, appro orders, Rx)			
2. Was there adequate control of pt's condition on d/c from 1st admit			
3. Were all other medical problems requiring Rx addressed on 1st admit			
4. Did the 2nd admit result from substandard care/ premature d/c from 1st admission			

____
Signature

APPENDIX A
MONTHLY REPORT
to
HCFA from AQAF

MONTH ____________________

YEAR ______________

FACILITY NAME	MC ADMISSIONS	MC DENIALS	TOTAL SNF DAYS/MONTH	TOTAL SNF DAYS/YEAR to DATE	TOTAL TRANSFER to ACF	TOTAL RECON.	DECISION
LTC #86							

APPENDIX A

ALABAMA QUALITY ASSURANCE FOUNDATION

MEDICARE LONG TERM CARE REPORT

MONTH OF ____________________

PRIOR APPROVAL

# of Prior Approval Calls Certified ____________

# of Prior Approval Calls Denied ____________

TOTAL ____________

CONTINUED STAY REVIEW

# Continued Stay Reviews Certified for Skilled Care ____________

# Continued Stay Reviews Denied ____________

TOTAL ____________

TRANSFERRED

# Patients Transferred from SNF to ACF ____________

# Certified Through Preadmission Review. ____________

# Denied Through Preadmission Review ____________

RECONSIDERATIONS

# Reconsiderations ____________

# Reinstated Medicare ____________

# Decisions Upheld as Denials ____________

APPENDIX A

MEDICARE LONG TERM CARE REPORTS
MONTH OF ____________________

# Readmissions from SNF to ACF within 14 days of discharge from acute care facility ____________________

# Readmissions resulting from substandard/premature care reasons ____________________

SECTION III
DATA PLAN

Data from claims payment (UB82) for skilled nursing facilities and acute care hospitals will be utilized as a data base for profiling. Quarterly statistics will be used to identify problem areas in the following categories:

1. Hospital readmission rate due to premature discharge/substandard care.
2. Hospital readmission rate from SNF by facility.
3. Death rate within 24, 48 and 72 hours of admission to nursing home.
4. Death rate within 24, 48 and 72 hours of admission to hospital.
5. Admissions from SNF for fracture and other trauma utilizing UB82 hospital readmission codes.
6. Average length of stay between acute care facility stays at SNFs.

The first quarter of data will be utilized to establish statewide death rates, readmission rates, SNF admission rates and SNF average length of stay between acute care facility stays. The statistics will be revised each of the subsequent quarters to refine the data base.

SECTION IV - FINANCIAL PLAN

I. The annual budget for long term care review of Medicare is at Enclosure I, supported by the personnel requirements at Enclosure II. It should be noted that $407,740 is probably less than Medicare is paying the nursing homes in Alabama (through their cost reports) to do their own review. AQAF is receiving $36,800 annually to do review in 24 small facilities with approximately 10% of the total Medicare nursing home admissions in Alabama. No funds are requested for any area already paid for by the PRO contract (CEO, Medical Director, support personnel, etc.).

II. Enclosure III is the FY 1982 Annual PSRO Personnel Requirements for total federal long term care review. The number of persons required in this proposal (13) is considerably less than the number in the PSRO Grant (22).

III. Enclosure IV is the FY 1982 Annual PSRO Grant Total LTC Review Budget of $726,815. The proposal cost to the PRO contract is $407,740.

ENCLOSURE I

MEDICARE LONG TERM CARE ANNUAL BUDGET
3,198 ADMISSIONS
7,000 BUDGETED REVIEWS

	FTE/HOURS	BUDGET
1. PERSONNEL		
A. Managerial	1	$ 24,500
B. Technical	1	13,000
C. LTC Review	10	179,000
D. Clerical	1	13,000
SUBTOTAL		229,500
2. FRINGE BENEFITS		73,440
3. CONSULTANTS		
A. Physicians	300 hours	16,500
B. Legal		2,000
4. CONTRACTOR		
A. Data		6,300
5. TRAVEL		
A. Local		31,000
B. Out of State		1,000
6. FURNITURE AND EQUIPMENT		1,000
7. OFFICE SPACE		6,000
8. OFFICE SUPPLIES		6,000
9. OTHER SUPPORT		
A. Telephone		35,000
TOTAL		$ 407,740

ENCLOSURE II

MEDICARE LONG TERM CARE REVIEW
PERSONNEL REQUIREMENTS

	FTE	TOTAL SALARY
A. MANAGERIAL		
Director of Long Term Care	1	$ 24,000
B. TECHNICAL		
Data Clerk	1	13,000
C. REVIEW COORDINATORS		
Review Supervisor	①	20,500
Review Coordinators	6	105,000
Prior Approval	②	35,000
Quality Review Coordinator	①	18,500
SUBTOTAL		$ 216,500
D. CLERICAL		
Secretary	1	13,000
TOTAL	13	$ 229,500

ENCLOSURE III

EXHIBIT V-1 PART II

PSRO ANNUAL BUDGET - Detailed Personnel

PSRO Name
Alabama Medical Revie
PSR
Inc. AL01

Award Period Dates
From
Month 04 Year 1981
To
Month 03 Year 1982

COST COMPONENTS			APPROPRIATED COST					MEDICARE TRUST FUND COSTS					TOTAL			
			PART I					PART II-NONDELEGATED HOSPITAL REVIEW			PART III	PART IV	PART I	PARTS II III	PARTS I II III	CURRENT GRANT PERIOD ESTIMATED EXPENDITURE
POSITIONS (Title of Positions)	Current FTE	Requested FTE	PROGRAM MANAGEMENT (1)	PROGRAM SUPPORT (2)	LONG-TERM CARE REVIEW (3)	AMBULATORY CARE REVIEW (4)	SPECIAL INITIATIVE PROJECTS (5)	NON-DELEGATED AC/CS CONC. REVIEW (6)	NON-DELEGATED QRS STUDIES (7)	OTHER REVIEW (8)	AREA-WIDE HOSP. REVIEW (9)	DEL. HOSP. REV. (10)	(11)	(12)	(13)	(14)
Executive Director	1.0	1.0	45,243													
Medical Director	1.0	1.0	10,000		32,400				10,978	9,352						
Assoc. Exec. Dir.	1.0	1.0	38,256													
Asst. to Exec.Dir.	1.0	1.0	14,264		6,114											
Executive Asst.	1.0	1.0	10,161		1,129											
Director - ACR	1.0	1.0									20,412					
Director - LTC	1.0	1.0			20,483											
Director - QRS	1.0	1.0			7,591				3,416		7,971					
Bookkeeper	1.0	1.0	5,640		5,640											
Accounting Clerk	.6	1.0	4,680		4,680											
Data Manager	1.0	1.0									16,442					
Review Coord-ACR	7.5	7.5						101,753								
Review Coord-LTC	17.2	17.22			16,680											
Prior Apvl.CoRd-LTC	2.0	2.0			28,074											
1 RC		1.0				13,500										

EXHIBIT V-1 PART I

PSRO ANNUAL BUDGET

PSRO Name: Alabama Medical Review, Inc.
PSRO No. 4AL01
Award Period Dates
From Month 04 Year 1981
To Month 03 Year 1982

COST COMPONENTS	Current FTE	Requested FTE	APPROPRIATED COST					MEDICARE TRUST FUND COSTS					TOTAL			
			PART I					PART II-NONDELEGATED HOSPITAL REVIEW			PART III	PART IV	PART I	PARTS II III	PARTS I II III	CURRENT GRANT PERI ESTIMATED EXPENDITU
			PROGRAM MANAGEMENT (1)	PROGRAM SUPPORT (2)	LONG-TERM CARE REVIEW (3)	AMBULATORY CARE REVIEW (4)	SPECIAL INITIATIVE PROJECTS (5)	NON-DELEGATED AC/CS CONC. REVIEW (6)	NON-DELEGATED QRS STUDIES (7)	OTHER REVIEW (8)	AREA-WIDE HOSP. REVIEW (9)	DEL. HOSP. REV. (10)	(11)	(12)	(13)	(14)
1. PERSONNEL																
a. Managerial	8.2	8.3	132,817		101,210								234,027		234,027	
b. Technical	.45	6.35			10,961				36,960		44,325		10,961	81,285	92,24	
c. Review Coordinators	33.0	34.00			244,754		13,500	101,753			101,613		258,25	203,366	461,62	
d. Clerical	10.2	11.6	39,718		37,205				4,946		35,022		76,92	39,968	116,891	
e. Subtotal Personnel Costs	55.8	60.25	172,535		394,130		13,500	101,753	41,906		180,960		580,165	324,619	904,784	
2. FRINGE BENEFITS			32,237		70,424		2,500	18,825	7,752		33,478		105,161	60,055	165,210	
3. CONSULTANTS	H O	U R S														
a. Physician Advisors	332	2360.			38,525			79,500					38,525	79,500	118,025	
b. Physicians	344	3435.	10,375		16,850				80,000		68,150		27,225	148,150	175,375	
c. HCPOTPs	136	291.	3,813		3,175								6,988		6,988	
d. Other LEGAL, AUDIT, TEMP. LABOR		400.	7,250		8,450								15,700		15,700	
e. Subtotal Consultants	,81	6487.	21,438		67,000			79,500	80,000		68,150		88,438	227,650	316,088	

1828

EXHIBIT V-1 PART I (cont'd)

PSRO ANNUAL BUDGET

PSRO Name

Award Period Dates
From
Month Year

PSRO No.

To
Month Year

COST COMPONENTS			APPROPRIATED COST					MEDICARE TRUST FUND COSTS					TOTAL			
			PART I					PART II-NONDELEGATED HOSPITAL REVIEW			PART III	PART IV	PART I	PARTS II III	PARTS I II III	CURRENT GRANT PERI ESTIMATED EXPENDITUR
4. CONTRACTOR (Name	Current FTE	Requested FTE	PROGRAM MANAGEMENT (1)	PROGRAM SUPPORT (2)	LONG-TERM CARE REVIEW (3)	AMBULATORY CARE REVIEW (4)	SPECIAL INITIATIVE PROJECTS (5)	NON-DELEGATED AC/CS CONC. REVIEW (6)	NON-DELEGATED QRS STUDIES (7)	OTHER REVIEW (8)	AREA-WIDE HOSP. REVIEW (9)	DEL. HOSP. REV. (10)	(11)	(12)	(13)	(14)
and Purpose)											8,520			8,520	8,520	
a. O.S.I.-Data Subcontractor											211,544			211,544	211,544	
b. Data Consultant-Dr. W. Bridges											272			272	272	
c. Second Opinion											17,173			17,173	17,173	
d. LTC-DATA Subcontractor					27,900								27,900		27,900	
5. TRAVEL																
a. Local Travel				9,224	57,417			7,737	11,597	17,742			66,641	37,076	103,717	
b. Out-of-Area Travel				4,629	2,117			900	2,329	1,537	900		6,746	5,666	12,412	
c. Subtotal				13,853	59,534			8,637	13,926	19,279	900		73,387	42,742	16,129	
6. FURNITURE AND EQUIPMENT				445	955			220	380	582	530		1,400	1,712	3,112	
7. OFFICE SPACE				25,942	11,118								37,060		37,060	
8. OFFICE SUPPLIES				13,368	12,479								25,847		25,847	
9. OTHER SUPPORT*				72,339	83,275		2,000	64,199					157,614	64,199	21,813	
0. INDIRECT COSTS (RATE %)																
1. DELEGATED HOSPITAL REVIEW FOR HOSPITALS W/O F.I.s																
2. TOTALS			226,210	125,947	726,815		18,000	273,134	143,964	19,861	521,527	1,550,649	1,096,972	958,486	2,055,458	

* Detail in PSRO's own format. See instructions.

DEPARTMENT OF HEALTH & HUMAN SERVICES

Health Care Financing
Administration

Region IV
101 Marietta Tower
Atlanta GA 30323

August 15, 1985

RECEIVED
AUG 19 1985
Ans'd............

MEDICARE
MEDICAID 20

John W. Miller, Chief Executive Officer
Alabama Quality Assurance Foundation
236 Goodwin Crest Drive, Suite 300
Twin Towers East
Birmingham, Ala. 35209

Dear Mr. Miller:

This is in further reference to your Long Term Care Proposal submitted to this office on April 3, 1985 and subsequently reviewed by the Project Officer and our Central Office.

We have been notified by Philip Gomez, Contracts Specialist, Baltimore, that a communication was received dated August 12, 1985, signed by Tony Tirone, Director of the Division of Program Operations, Baltimore, disapproving the proposal as an addition to your PRO contract at this time. The memo stated, "the PRO's request for funding for the Long Term Care proposal is disapproved pending incorporation into a pilot to be performed at a later date."

We will attempt to get more details if available and notify you of any new developments.

If you have any questions regarding the foregoing, please contact your Project Officer.

Sincerely,

Clarence J. Boone

Clarence J. Boone
Associate Regional Administrator
Health Standards & Quality Division
Region IV

RB

301-597-0417

THE KANSAS FOUNDATION FOR MEDICAL CARE INC.
2953 S.W. Wanamaker Drive / Topeka, Kansas 66614
Telephone: (913) 273-2552

President:
Louis M. Culp, M.D.
Kansas City

Vice President:
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Newton

Secretary:
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Junction City

Treasurer:
George R. Learned, M.D.
Lawrence

Executive Director:
Larry W. Pitman
Topeka

Medical Director
G. Rex Stone, M.D.
Manhattan

April 3, 1985

Ms. Elizabeth Faykus
Contract Specialist
Department of Health and Human Services
Health Care Financing Administration
DPS/Contract Branch - RFP-HCFA-84-015
Room 322, East Highrise Building
6325 Security Boulevard
Baltimore, Maryland 21207

RE: HCFA 500-84-0506
#0065

Dear Ms. Faykus:

On March 20, 1985, KFMC received Peer Review Organization Manual transmittal #IM85-2 from the Department of Health and Human Services, Health Care Financing Administration. It appears instructions in this manual cause changes which will produce significant increases in the fixed price of the contract. We are unable to fully detail the specific increases at this time. We do, however, want to notify you according to Article XXVI - Changes of our claim for potential increase in the fixed price of the contract.

As soon as a detail of the increase can be finalized, we will forward this to your attention.

If you have any questions regarding this matter, please let me know.

Sincerely,

Larry W. Pitman

Larry W. Pitman
Executive Director

LP/de

xc: Ms. Brenda Burton, Project Officer

964B-2

O

NE. 2

NEBRASKA FOUNDATION FOR MEDICAL CARE, INC.
Suite 801 CTU Building
1221 N Street
Lincoln, Nebraska 68508

Telephone: (402) 474-7471

President
Herbert E. Reese, M.D.
Lincoln

Vice President
David Bosen, M.D.
Kearney

Secretary-Treasurer
O.R. Hayes, M.D.
Lincoln

Medical Director
John D. Coe, M.D.
Omaha

April 3, 1985

Mr. Philip Gomez
Contract Specialist
Department of Health and Human Services
Health Care Financing Administration
DPS/Contract Branch - RFP-HCFA-84-015
Room 322, East Highrise Building
6325 Security Boulevard
Baltimore, Maryland 21207

RE: HCFA 500-84-0529
#0019

Dear Mr. Gomez:

On March 20, 1985, KFMC received Peer Review Organization Manual transmittal #IM85-2 from the Department of Health and Human Services, Health Care Financing Administration. It appears instructions in this manual cause changes which will produce significant increases in the fixed price of the contract. We are unable to fully detail the specific increases at this time. We do, however, want to notify you according to Article XXVI - Changes of our claim for potential increase in the fixed price of the contract.

As soon as a detail of the increase can be finalized, we will forward this to your attention.

If you have any questions regarding this matter, please let me know.

Sincerely,

Kenneth E. Neff

Kenneth L. Neff
Executive Director

LWP/de

964B-3

xc: Mr. Ben Gruber, PRO Project Officer

Reporting Date: 4 / 3 / 85

NDHCRI INCIDENCE REPORT TO REGIONAL OFFICE

Patient Name: [redacted] HIC NO.: [redacted] Age: 78

Admit Date: 10/ 8 / 84 Hosp. Name [redacted] MPR No.35-[redacted]

Physician Name: [redacted] M.D. License No.: [redacted]

Reviewer Numbers: R.S.[redacted] P.A.[redacted] Reviewed: 3 / 29 / 85

Incidence Type:

X A. Readmission Subsequent to a Pre-mature Discharge
___B. Transfer Of a Questionable Nature
___C. Hospital Initiated Denial Not Reported on Monthly List
___D. Inappropriate Hosp. Init. Den. Issued Prior to DRG ALOS

(Narrative description of the problem or discrepancy using as accurate direct language as possible. Use physicians orders and physician advisor notes for quotations where possible.)

Patient's dates of admission were 10/8/84 through 10/19/84 and 10/25/84 through 11/17/84. The patient's diagnoses during the first admission were pneumonia, dehydration, coronary artery disease, ASHD and atrial fibrillation. One day prior to discharge the record documentation included the fact that the patient's stools were blood streaked, were positive for blood.

The patient was readmitted for gastrointestinal hemorrahge, posthemorrhagic anemia, duodenal ulcer, multiple myeloma and hypertension.

The physician advisor's comments were: I feel the discharge was premature. There was no doubt that there was blood in the colostomy at the time of discharge. Hgb was 12 gram. This became a significant observation in the following days.

Distribution - Type	A B C D
NDHCRI	A B C D
Regional Office	A B C D
Hospital	A B C D
Attending Physician	A B C D
Fiscal Intermediary	D
Patient	D

FOREIGN AFFAIRS
JOINT ECONOMIC COMMITTEE
SELECT COMMITTEE
ON AGING

WASHINGTON OFFICE:
133 CANNON HOUSE OFFICE BUILDING
WASHINGTON, DC 20515
(202) 225-6306

2D DISTRICT, MAINE

Congress of the United States
House of Representatives
Washington, DC 20515

FEDERAL BUILDING
202 HARLOW STREET, ROOM 209
BANGOR, ME 04401
(207) 945-0432
●
146 MAIN STREET
AUBURN, ME 04210
(207) 786-2451
●
187 STATE STREET
POST OFFICE BOX 722
PRESQUE ISLE, ME 04769
(207) 764-5124

April 4, 1985

RECEIVED
APR 11 1985
HEALTH CARE REVIEW

Alton M. Paull, M.D.
President
Health Care Review, Inc.
345 Blackstone Boulevard
Providence, Rhode Island 02906

[illegible]
~~Virginia~~

Dear Dr. Paull:

[illegible]
Re: Maine
Preadmission
Review

I am writing to you on behalf of Mr. A R , Fort Fairfield, Maine, regarding his outpatient cataract surgery performed at the Aroostook Medical Center, Gould Division in Presque Isle.

I am bringing this to your attention because I am concerned about the strong emphasis on performing cataract surgery as outpatient proceedures. I understand that due to improved technology it is medically safe to perform most such proceedures in an ambulatory manner. However, I also am aware how important post-surgery care is, because complications can in some cases result in loss of sight. It, therefore, seems to me that each patient must be assessed separately, taking all factors into account, such as, age of patient, family situation, ability of self-care, and access to post-surgery physician office visit.

In Mr. R 's situation, he was not able to get to the doctor's office the day following surgery because the inclement weather made traveling the 12 miles between his home and the doctor impossible. Mr. R is a 67-year old man who had cataract surgery on one eye three years ago. At that time, the operated eye became infected and he had to stay in the hospital for eight days. Naturally Mr. R was frightened that history would repeat itself, and yet he felt helpless in not being able to get to his doctor for a post-surgery office visit.

I would like you to review Mr. R 's case and explain to me exactly what factors enter into the decision of ambulatory versus in-hospital surgery for older individuals. I would also like to know who makes the final decision.

Thank you for your expeditious consideration of this matter.

Sincerely,

Olympia Snowe

OLYMPIA J. SNOWE
Member of Congress

OJS/bc
enclosure

IN MAINE, CALL TOLL FREE
1-800-432-1599

Reporting Date: 4 / 17 / 85

NDHCRI INCIDENCE REPORT TO REGIONAL OFFICE

Patient Name: ____________________ HIC NO.: ___________ Age: 83

Admit Date: 10/ 8 /84 Hosp. Name [redacted] MPR No.35-[redacted]

Physician Name: ____________________ M.D. License No.: __________

Reviewer Numbers: R.S. [redacted] P.A. [redacted] Reviewed: 4 / 15 / 85

Incidence Type:

___A. Readmission Subsequent to a Pre-mature Discharge
_x_B. Transfer Of a Questionable Nature
___C. Hospital Initiated Denial Not Reported on Monthly List
___D. Inappropriate Hosp. Init. Den. Issued Prior to DRG ALOS

(Narrative description of the problem or discrepancy using as accurate direct language as possible. Use physicians orders and physician advisor notes for quotations where possible.)

This is an 83 year old male who was admitted into the [redacted] [redacted] [redacted], with the diagnosis of severe congestive heart failure. He was in the hospital from 9/24/84 until 10/8/84 at which time he was transferred into the swing bed program. The patient expired 10/13/84. The medical record was reviewed by the review specialist. It was referred to the physician advisor was it was felt that the patient needed acute care and that the transfer into the swing bed was questionable. The patient was very dyspneic, he had marked edema in his legs, his BUN, creatinine levels were elevated. The physician advisor reviewed the record and his comments follow: "Due to the degree of congestive heart failure, this patient should have stayed at an acute level of care."

Distribution - Type	A B C D
NDHCRI	A B C D
Regional Office	A B C D
Hospital	A B C D
Attending Physician	A B C D
Fiscal Intermediary	D
Patient	D

DEPARTMENT OF HEALTH AND HUMAN SERVICES

February 11, 1985

Project Officer, Medical Review Branch
Division of Health Standards and Quality — Refer to: [illegible]
Health Care Financing Administration, Kansas City — IA.1[illegible]
Contract Modification - Contract Number 500-84-051[illegible]

William J. Tate, Contracting Officer
Division of Procurement Services
Contracts Branch
Health Care Financing Administration
Room 339, East High Rise
6325 Security Boulevard
Baltimore, MD 21207

Attention: Burton Stackler

The Iowa Foundation for Medical Care (IFMC) has been asked by the Office of the Inspector General (OIG) to perform review activities at the in , Iowa. The review of outpatient records is outside the normal scope of Peer Review Organization (PRO) inpatient review activities. This type of review falls within Article III.B.2.i. of the PRO contract. Depending on the results of the review, sanction activity under Article III.B.2.h. may result. IFMC's letter (copy attached) dated January 15, 1985, correspondence #85-20, requests additional funds for the review activity.

By way of background, the situation started with IFMC (then the PSRO) finding questionable cases involving inpatient admissions for pacemaker procedures. When IFMC intensified inpatient review efforts, the fiscal intermediary (FI) became aware of questionable billings for outpatient pacemaker related procedures. The FI raised questions of improper outpatient billing and quality of care with the OIG. The OIG asked the PRO to review a small number of cases in order to determine whether or not there was a problem worthy of further investigation. The PRO's report of this review was made by letter from the PRO to the OIG dated December 23, 1984 (copy attached).

In the PRO's letter of December 26, 1984, the PRO recommended a course of action for further investigation which involves: (1) 100% preadmission screening of inpatient claims, (2) 100% DRG validation of inpatient claims, (3) conduct of a physician assessment at the hospital, and (4) preprocedure review of certain outpatient procedures. The first two activities and that portion of the third activity which deals with inpatient cases fall within the scope of the PRO's expected review activity as part of the

FILE
COPY

OFFICE	SURNAME	DATE	OFFICE	SURNAME	DATE	OFFICE	SURNAME	DATE
MRB		2/11/85						
[illegible]		2/11						

275

DEPARTMENT OF HEALTH AND HUMAN SERVICES

original fixed price contract. Activity relating to review of outpatient cases falls within Article III.B.2.1. of the PRO contract for which additional reimbursement is to be made to the PRO. The letter (attached) dated January 24, 1985, from the OIG to the PRO requests the PRO to conduct outpatient review activity and is considered to provide the PRO the authority to conduct such reviews.

It is my recommendation that a contract modification be processed which would incorporate into Article III.B.2.1. of the scope of work, through reference, the activity in the OIG's letter dated January 24, 1985.

With regard to additional financing, this seems to be an activity which lends itself well to cost reimbursement funding rather than fixed amount funding. This is primarily true because we cannot predict the exact volume of review activity. For example, the PRO has made estimates based on three calendar quarters of review activity while the OIG has asked for one quarter of review after which a decision regarding continued activity would be made. Also, the actual number of outpatient claims to be reviewed can only be estimated at this point.

It is my recommendation that the estimates in the PRO's correspondence #85-20 be accepted with regard to payment rate per hour and time required for each type of activity with actual reimbursement based on number of cases actually reviewed. This should apply to staff review activities for outpatient review, management and administrative support related to outpatient review, and physician review activities for outpatient review. Committee expenses, physician travel expenses, and legal expenses should be reimbursed in the same proportion to total expenditures that time spent on outpatient activities have to the total time spent on such activities at this facility. This recommendation is based on the premise that case reviews, DRG validations, committee expenses, physician consultation, legal expenses, etc. relating to inpatient cases are covered under the original fixed price of the PRO contract.

If you have questions or if I can provide further assistance, please call.

Benny Gruber

Attachments

cc: Tony Tirone, HSQ, OMR
Fred Ferree, IFMC
Frank Kram, OIG, OHFI

bcc: Lear/Gruber
HCFA:DHSQ:MRB:BG:lsf:2/11/85:X5746

FILE
COPY

OFFICE	SURNAME	DATE	OFFICE	SURNAME	DATE	OFFICE	SURNAME	DATE

Re: maine
pre-admission
Review

Health Care Review Inc.

371 Fore Street
Rinaldi Building
Suite 201
Portland, Maine 04101
Tel. (207) 879-0544

Quality Health
Care
1973

Edward J. Lynch
Executive Vice President

April 23, 1985

Olympia J. Snowe
Member of Congress
Congress of the United Stated
House of Representatives
33 Cannon House Office Building
Washington, DC 20015

Dear Representative Snowe:

This letter is in answer to the case of Mr. Arnold Roach, Fort Fairfield, Maine, regarding his outpatient cataract surgery performed at the Aroostook Medical Center. Your communication to Alton M. Paull, M.D., President of Health Care Review, Inc. has been forwarded to me from the Rhode Island office for response.

There are several issues involved in Mr. Roach's letter, issues which need to be addressed as directly as possible in answering his letter:

I. Can cataracts be removed safely as an outpatient procedure?

Many argue from the premise that HCFA mandated outpatient cataract surgery merely as a cost containment measure, without ever considering this question. Most certainly medical consultants, in this case ophthamologists, advised HCFA that cataract surgery could be performed safely as an outpatient procedure. It has been my personal experience through referring my patients to an ophthamologist in Portland that the surgery is done safely in the outpatient setting. I have never had a patient of mine complain about the outpatient setting. The round trip from Norway to Portland is 104 miles and my patients who are having outpatient cataract surgery must make the trip twice for the procedure, once on the day of the surgery and then again the next day for a follow-up visit with the ophthamologist. Nevertheless, I asked this question of William S. Holt, M.D., an ophthamologist in Portland who subsequently formed an ad hoc committee and drafted the enclosed guidelines of admission criteria for inpatient cataract, irridectomy, and discission surgery. These criteria have subsequently been approved by the Maine Society of Eye Physicians and Surgeons, William Clark, M.D. of Bangor, President.

Health Care Review Inc.

371 Fore Street
Rinaldi Building
Suite 201
Portland, Maine 04101
Tel. (207) 879-0544

Quality Health
Care
1973

Edward J. Lynch
Executive Vice President

Page Two
Olympia J. Snowe
Member of Congress
April 23, 1985

II. Are local physicians in control of the review process or is it true that, as is stated in Mr. Ginty's response to Mr. Roach, that "the decision has now been taken out of the hands of local physicians and local hospitals".

The admissions criteria as formulated by Dr. Holt's committee and its subsequent approval by the Maine Society, answers not only the first question raised above but also this question. Clearly, Maine ophthamologists are directly involved in the process of peer review. Further, Dr. Holt will, on May 21, present and elaborate upon these admission criteria to the Nurse Review Coordinators of Health Care Review to provide them with direction when reviewing and selecting charts for physician review. In turn, when the Nurse Coordinators select charts which they feel might require denial of admission, these charts will be referred to physician reviewers for final decision. Physician reviewers will in the case of cataract surgery receive copies of the admissions criteria as developed by the ad hoc committee. This will serve to guide the physician reviewer in coming to a decision as to whether or not to issue a denial of stay. Ultimately, the decision will rest with the physician and his or her good medical judgment about whether admission was medically necessary. Documentation of the medical necessity of admission in the patient record is crucial to a physician making such a decision. The physician reviewers, it should be stated, are in every case Maine physicians. Local physicians are indeed in control of the review process. That is, simply stated, the ultimate reason why I became involved in this whole peer review process.

III. What do we do about the "snow storm controversy?"

Is Maine different from Rhode Island, from Idaho, from Oregon? These are tough questions and involve many issues. Medicare has never covered the social admission to a hospital. Is distance from a hospital per se a factor arguing for medical necessity of admission? I believe it is not. Other forward-thinking institutions, such as Cary Medical Center in Caribou and Eastern Maine Medical Center in Bangor seem to feel the same way. They are developing hotel/motel facilities for outpatients having outpatient surgical procedures at their

Health Care Review Inc.

371 Fore Street
Rinaldi Building
Suite 201
Portland, Maine 04101
Tel. (207) 879-0544

Edward J. Lynch
Executive Vice President

Page Three
Olympia J. Snowe
Member of Congress
April 23, 1985

facilities. These will be low cost facilities; they will not be free, as is a Medicare-funded overnight stay in a hospital. Nevertheless, they will be affordable. The distance from Norway to Portland has never been a barrier to my patients and from the experience of my patients, distance and geography have never become an issue in my mind. As well, in North Carolina, for example, ophthamologists themselves pay for an overnight stay in a hotel for their patients coming from long distances to have outpatient cataract surgery!

What about the snow storms? One must remember that cataract surgery is an elective procedure and can be rescheduled. Often it is our experience at Oxford Hill Internal Medicine that on the morning after a big snow storm the phone rings incessantly from 8-9 a.m. with patients calling in cancellations. The three of us internists are left with an empty day and usually send our staff home at noontime. It is from a business standpoint I suppose an economic loss, but such are the exigencies of medical practice. This same kind of approach to outpatient cataract surgery can certainly obtain, and I believe if patients are educated in the elective nature of the surgery and in the flexible nature of scheduling, they will certainly accept it. There is no need for the scenario of a patient fighting a blinding snow storm to get to the hospital to have the surgery. Certainly, once the surgery has been performed and in that rare circumstance where patient and doctor are trapped in the hospital because of a huge storm with no immediate facilities available, no one would argue with admitting that patient out of medical necessity. Clear documentation in the record is all that is required.

Health Care Review Inc.

371 Fore Street
Rinaldi Building
Suite 201
Portland, Maine 04101
Tel. (207) 879-0544

Health Care Review Inc. Rhode Island
Quality Health Care
1973

Edward J Lynch
Executive Vice President

Page Four
Olympia J. Snowe
Member of Congress
April 23, 1985

Outpatient cataract surgery is very possible, local Maine physicians are in control of reviewing such surgery, and patient education and physician flexibility are the keys to its success.

Yours sincerely,

Michael A. LaCombe, M.D.
Medical Director
for Maine Health Care Review, Inc.

MAL:jj

cc: William S. Holt, M.D.
Frederick Crissafulli, M.D.
Edward J. Lynch

Reporting Date: 5 / 1 /85

NDHCRI INCIDENCE REPORT TO REGIONAL OFFICE

Patient Name:____________________ HIC NO.:__________ Age:___

Admit Date:___/___/___ Hosp. Name__________ MPR No.35-_____

Physician Name:___ __________ M.D. License No.:__________

Reviewer Numbers: R.S.____ P.A.________ Reviewed: ___/___/___

Incidence Type:

_X_A. Readmission Subsequent to a Pre-mature Discharge
___B. Transfer Of a Questionable Nature
___C. Hospital Initiated Denial Not Reported on Monthly List
___D. Inappropriate Hosp. Init. Den. Issued Prior to DRG ALOS

(Narrative description of the problem or discrepancy using as accurate direct language as possible. Use physicians orders and physician advisor notes for quotations where possible.)

This patient was admitted on 1-12-85 for compression fracture of T8 and discharged on 1-19-85. The patient was still experiencing a great deal of pain at the time of discharge. The patient was readmitted on 1-22-85 with the diagnosis of compression fracture T8. The progress note of 1-23-85 states "the patient was sent home too early." NDHCRI's Physician Advisor reviewed this case. His comments are as follows: "After review of this record, I find the patient was prematurely discharged from the stay of 1-19-85 which resulted in a readmission on 1-22-85."

Distribution - Type	A B C D
NDHCRI	A B C D
Regional Office	A B C D
Hospital	A B C D
Attending Physician	A B C D
Fiscal Intermediary	D
Patient	D

HCFA/HSQ Received MAY 7 '85

051:85024

HCFA

HCFA [illegible]

May 7, 1985

MAY 21 5 21 PM

TO: Hon. Lawrence J. Denardis
Office of Legislation
Department of Health & Human Services
Room 416G Humphrey Building
200 Independence Avenue, S.W.
Washington, D.C. 20201

FROM: James M. Streeto, M.D.
65 Jefferson Street
Hartford, Ct. 06106

RE: Peer review process and disapproval of Medicare admissions.

The attached correspondence is being forwarded to your office for appropriate action.

An early reply in duplicate would be appreciated (to the attention of Ms. Pat Gilroy).

Sincerely,

CHRISTOPHER J. DODD
United States Senator

PLEASE SEND RESPONSE TO: UNITED STATES SENATE
WASHINGTON, D.C. 20510

CORRESPONDENCE

85 MAY 17 P2:39

JAMES M. STREETO, M.D., F.A.C.P.
85 JEFFERSON ST.
HARTFORD, CONN. 06106

April 25, 1985

The Honorable Christopher J. Dodd
Senate Office Building
Washington, DC 20510

Dear Senator Dodd:

I am a physician in clinical practice in the City of Hartford, Connecticut. I have been in private practice for nearly 15 years. I am also active in teaching functions at Hartford Hospital and at the University of Connecticut Health Center. I am writing to you about what I consider to be a very serious matter which is developing in the State of Connecticut; and, more specifically, in our area. As you know, we have established a peer review organization to evaluate Medicare admissions. These reviews have been conducted in this area for one or two years. The doctors' records are reviewed by a non-physician or physician. This review is anonymous and remains so. If the reviewer feels the admission to be unnecessary, the physician is notified and soon after the patient is advised that his admission was not necessary. I have had several of my patients receive such denial letters. I have appealed each denial. When our own reviewing board at Hartford Hospital reviewed two of my denials, my appeal was upheld; the other appeals are pending. Many of my colleagues are receiving similar denials of care. We do not have an opportunity to discuss our medical judgments with the reviewers. Most of us make every effort to outline the reasons why we are hospitalizing Medicare patients. The review mechanism is arbitrary and unfair. It is influencing medical practice to a great extent in this area. The influence it is having is negative, almost uniformly.

cc P.O. [illegible]

I do not object to the principle of admission review. The way it is being conducted in the State of Connecticut is unthinking and unfair. This is the worst possible way to attempt to contain medical costs. The quality of care is being affected.

I appreciate the opportunity to bring this matter to your attention.

Sincerely yours,

James M. Streeto MD

James M. Streeto, M.D.

JMS:mts

1

OMPRO

OREGON MEDICAL PROFESSIONAL REVIEW ORGANIZATION

1220 S.W. Morrison, Suite 300
Portland, Oregon 97205
(503) 243-1151

May 8, 1985

Don Tabor
Health Care Financing Administration
East High Rise Building, Room G-10-A
6325 Security Blvd.
Baltimore, MD 21207

Dear Don:

Based on telephone discussions with the Region X HCFA office on 5-1-85, 5-2-85 and 5-7-85 and on additional requirements for DRG validation not previously described in regulation or review directives, OMPRO is filing an action plan that will change the staffing requirements for DRG validation in the State of Oregon.

The action plan, appended to this cover letter, changes the make-up of the review team to incude an Accredited Record Technician (ART) as a full-time regular review team member. Our philosophy about the appropriate way in which DRG validation should be conducted has not changed, however, to conserve management time and resources in dealing with this issue, we find it necessary to add a technical coding expert to the review team, above and beyond the clinical reviewers, who also are trained and experienced in coding. This will assure that purely technical/coding issues are resolved on-site at the time the record is reviewed. This will also meet the additional requirements on PROs, currently not described in regulation or review directives, to correct all coding errors, whether or not the DRG designation is changed. In addition, per our telephone discussion with the regional office of 5-1-85, we are required to provide feedback to all hospitals on coding errors, whether or not it affects the DRG assignment, and furthermore we are also required to provide the coding changes, in addition to those currently provided, on all DRG changes, to our data processor.

Because this level of review was not described or considered at the time of the 1984 contract negotiations in Baltimore, this will notify you of OMPRO's intent to request a second year contract modification on the basis of additional work and manpower requirements.

Sincerely,
OREGON MEDICAL PROFESSIONAL REVIEW ORGANIZATION

Robert A. Berry
President

RAB:mb
cc: Kathy Riley

DEPARTMENT OF HEALTH & HUMAN SERVICES
Health Care Financing Administration

6325 Security Boulevard
Baltimore, MD 21207

MAY 09 1985

~~GC~~
~~BCF~~

file IA 2

Mr. Fred Ferree
Iowa Foundation for Medical Care
Colony Park
3737 Woodland Avenue, SUite 500
West Des Moines, Iowa 50265

Dear Mr. Ferree:

This is in response to your letter of February 5, 1985 requesting additional funds to perform review activity under PRO Directive #5, review DRG 462 cases. No modification to Contract No. 500-84-0513, for this purpose, can be issued at this time.

Any increase in work created by review of DRG 462s will be offset by the decrease in workload as a result of the modifications in APM and required medical review activities in the recently issued Interim Manual Instructions, IM-85-2, dated March 1985.

If you find that additional funds are required as a result of this manual issuance, IM-85-2, please submit a detailed request for additional funds, explaining all changes in level of review activity, with justification for budget change.

Sincerely yours,

Burton Steckler

Burton Steckler
Contract Specialist

South Carolina Medical Care Foundation
P.O. Box 21667 • Columbia, South Carolina 29221
Telephone (803) 798-0053 Toll Free in S.C. (800) 922-1840

Leonard W. Douglas, M.D.
President
Halsted M. Stone, M.D.
Vice President
Edward W. Catalano, M.D.
Secretary/Treasurer
William H. Barnwell, II, M.D.
U. Hoyt Bodie, M.D.
William J. Goudelock, M.D.
William M. Hull, Jr., M.D.
Robert K. Mason, M.D.

May 10, 1985

MAY 1985
RECEIVED
REGION IV
HCFA-DHSQ-PSRO

MEMORANDUM

TO: Regional Office

FROM: WF Wanda Fields, Manager, Central Office Review

SUBJECT: Referrals to Regional Office--Premature Discharges for Month of April 1985

Attached are copies of correspondence sent to a physician regarding prematurely discharging Medicare patients.

The Quality Assurance Committee reviewed cases referred by review coordinators and determined that this physician has a pattern of prematurely discharging patients. Committee has placed this physician under 100% quality review.

WF:ek

9/5/85
Wanda says when last phys. review
committee met in Aug. reviewers had not
yet finished reviewing this doctor's case.
Therefore, a decision about him will
be made until Oct. meeting.
I mentioned the Transmittal 5 effective
July 25 & Wanda said he might very
well be a prime candidate for Sanction

) Larry

South Carolina Medical Care Foundation
P.O. Box 21667 • Columbia, South Carolina 29221
Telephone (803) 798-0053 Toll Free in S.C. (800) 922-1840

Leonard W. Douglas, Jr.
President
Harold M. Stone, M.D.
Vice-President
Edward W. Coleman, M
Secretary-Treasurer
William H. [illegible], M.D.
U. Hoyt Bodie, M.D.
William J. [illegible], M
William M. Hull, Jr., M.D.
Robert E. Mason, M.D.

April 22, 1985

Dear Dr.

The Quality Assurance Committee of the South Carolina Medical Care Foundation is responsible for monitoring the medical care delivered to federal beneficiaries in South Carolina. As part of this process, the Committee recently conducted a review of ten (10) medical records of federally funded patients treated by you at [redacted] Hospital. The Committee had questions as defined on the enclosed case-by-case. Specifically, the Committee is concerned about those cases where you have documented that the patient is not ready for discharge, but because of DRG constraints, you are doing so. These cases include records [redacted], and [redacted] DRGs are used to assign hospital reimbursement, and should not be interpreted as instruction to physicians to prematurely discharge a patient from an acute care setting. The decision as to a patient's medical care needs continues to rest with the attending physician. Hospitals may request outlier payment for those complicated cases where a patient's length of stay or cost of services exceeds standard DRG parameters.

The Committee requests a written reply by May 10, 1985 containing information pertinent to explaining the outlined questions. Representatives of the Committee will be happy to meet with you for peer review and discussion. Simply contact the Foundation's office to arrange a meeting.

The Committee is placing you under 100% Medicare review until all questions raised are resolved.

Feel free to contact me if you have any questions. Again, Committee encourages you to meet with representatives of the Committee for peer review and discussion and explanation of DRGs and prospective payment.

Sincerely,

Robert N. Milling, M.D.
Chairman

RNM:bag

Enclosure

FI ID [illegible] / [illegible]

Case-by-Case Summary

.ı Information	South Carolina Medical Care Foundation Findings
Name: '.D.#: Age: 72 Admission: 7/21/84 - 8/9/84 Diagnosis(es): Gangrene right first and fourth toes, Abscess right great toe, P.V. insufficiency Aortic Stenosis, 1° A-V Block	Question the use of ASA and Coumadin. Coumadin was given from 8/5 - 8/8 with no prothrombin times done. Possible premature discharge - progress notes on 8/9 states "toe color poor and looks worse this a.m." Patient discharged on same day. Case of premature discharge
ame: .D.#: Age: 54 imission: 9/9/84 - 9/14/84 iagnosis(es): Left Heart Failure, ngina Pectoris, PVC's, NIDUM, ypokalemia	Discharge appears premature with no potassium re-evaluation after admission. Discharge summary states "Holter monitor was put on her chest and the report is not back however, because of problems and pressures with DRG's she is discharged and will be treated for whatever the Holter monitor states when she returns. To me this is rushing the situation but that is the way we have got to do it now." Sample — case of premature discharge
me: D.#: Age: 68 mission: 9/4/84 - 9/24/84 9/26/84 - 10/13/84 agnosis(es): 9/4/84 to 9/24/84: ute Ant. MI, Angina Pectoris, ght Pleural Effusion, Uncontrolled DM 26/84 to 10/13/84: Acute lmonary Edmea, Acute MI, Poorly ntrolled IDDM	First discharge appears premature. Patient was complaining of chest pain 24° prior to discharge on 9/24/84. On second admission 9/26/84 patient still complaining of chest tightness. Blood Sugar on 10/13 elevated at 205 mg/%. case of premature discharge

1 9 1985

STANDARD FORM 30, JULY 1966
GENERAL SERVICES ADMINISTRATION
FED. PROC. REG. (41 CFR) 1-16.101

AMENDMENT OF SOLICITATION/MODIFICATION OF CONTRACT

PAGE 1 OF 1

1. AMENDMENT/MODIFICATION NO. THREE (3)
2. EFFECTIVE DATE 5/15/85
3. REQUISITION/PURCHASE REQUEST NO.
4. PROJECT NO. (If applicable)

5. ISSUED BY CODE
Department of Health & Human Services
Health Care Financing Administration
DPS/Contract Branch, Rm. G-10-A EHR
6325 Security Boulevard
Baltimore, MD 21207

6. ADMINISTERED BY (If other than block 5) CODE

7. CONTRACTOR NAME AND ADDRESS (Street, city, county, state, and ZIP Code) CODE FACILITY CODE
Nevada Physicians Review Organization
3660 Baker Lane
Reno, Nevada 89509

8.
☐ AMENDMENT OF SOLICITATION NO.
DATED (See block 9)
☒ MODIFICATION OF CONTRACT/ORDER NO. 500-84-0509
DATED 07/11/84 (See block 11)

9. THIS BLOCK APPLIES ONLY TO AMENDMENTS OF SOLICITATIONS

☐ The above numbered solicitation is amended as set forth in block 12. The hour and date specified for receipt of Offers ☐ is extended, ☐ is not extended.

Offerors must acknowledge receipt of this amendment prior to the hour and date specified in the solicitation, or as amended, by one of the following methods:

(a) By signing and returning ___ copies of this amendment; (b) By acknowledging receipt of this amendment on each copy of the offer submitted; or (c) By separate letter or telegram which includes a reference to the solicitation and amendment numbers. FAILURE OF YOUR ACKNOWLEDGEMENT TO BE RECEIVED AT THE ISSUING OFFICE PRIOR TO THE HOUR AND DATE SPECIFIED MAY RESULT IN REJECTION OF YOUR OFFER. If, by virtue of this amendment you desire to change an offer already submitted, such change may be made by telegram or letter, provided such telegram or letter makes reference to the solicitation and this amendment, and is received prior to the opening hour and date specified.

10. ACCOUNTING AND APPROPRIATION DATA (If required)
CAN: 55998005 Allowance: 961 Amount Certified: $2,456.00
APPR: 7520X8005 OB CL.: 259Y

11. THIS BLOCK APPLIES ONLY TO MODIFICATIONS OF CONTRACTS/ORDERS

(a) ☐ This Change Order is issued pursuant to ___
The Changes set forth in block 12 are made to the above numbered contract/order.

(b) ☐ The above numbered contract/order is modified to reflect the administrative changes (such as changes in paying office, appropriation data, etc.) set forth in block 12.

(c) ☒ This Supplemental Agreement is entered into pursuant to authority of 41 U.S.C. 252 (c)(15) and Mutual Agreement of Both Parties
It modifies the above numbered contract as set forth in block 12.

12. DESCRIPTION OF AMENDMENT/MODIFICATION

Above referenced contract, as modified, is hereby further modified as follows:

I. ARTICLE XIX, Consideration and Payment

A. Increase the total fixed price amount of this contract for the Two (2) year period of performance by $2,456.00 from $1,240,182.00 to $1,242,638.00. The additional $2,456.00 represents partial payment for sanction activity as requested by contractor in letter dated March 18, 1985.

II. All other terms and conditions of the contract, as modified, remain unchanged.

Except as provided herein, all terms and conditions of the document referenced in block 8, as heretofore changed, remain unchanged and in full force and effect.

13. ☐ CONTRACTOR/OFFEROR IS NOT REQUIRED TO SIGN THIS DOCUMENT ☒ CONTRACTOR/OFFEROR IS REQUIRED TO SIGN THIS DOCUMENT AND RETURN 3 COPIES TO ISSUING OFFICE

14. NAME OF CONTRACTOR/OFFEROR
BY (Signature of person authorized to sign)

17. UNITED STATES OF AMERICA
BY William J. Tate (Signature of Contracting Officer)

15. NAME AND TITLE OF SIGNER (Type or print)
Holly J. Pecetti
Executive Vice President

16. DATE SIGNED 6/6/85

18. NAME OF CONTRACTING OFFICER (Type or print)
William J. Tate

19. DATE SIGNED 6-17-85

289 59-303

Nevada Physicians

SANCTION

EXPENSES

DATE	EXPENSE INCURRED - DIRECT	AMOUNT
08/16/84	Legal Consultation	$ 85.00
10/04/84	Physician Advisor	25.00
10/09/84	Physician Advisor	100.00
10/09/84	Physician Advisor	100.00
10/09/84	Physician Advisor	100.00
10/09/84	Physician Advisor	100.00
10/09/84	Physician Advisor	100.00
10/09/84	Physician Advisor	100.00
10/09/84	Travel Expense	6.00
10/09/84	Travel Expense	247.00
10/09/84	Travel Expense	218.00
10/09/84	Travel Expense	218.00
11/09/84	s - Sanction Transcript	417.00
12/13/84	Physician Advisor	100.00
12/21/84	Physician Advisor	300.00
12/21/84	Physician Advisor	50.00
01/16/85	Copies - Sanction Hearing (1716 @ .053¢)	90.95
02/01/85	Copies - Sanction Hearing (90 @ .05¢)	4.50
02/08/85	Copies - Sanction Hearing (75 @ .05¢)	3.75
02/08/85	Shipping Charges - Inspector General's Office	64.00
10/10/84	Copies - Lawyer	27.00
	TOTAL EXPENSES INCURRED - DIRECT	$2456.00

DEPARTMENT OF HEALTH & HUMAN SERVICES

Health Care Financing Administration

6325 Security Boulevard
Baltimore, MD 21207

NE. 2

HEW
HCFA-HSQ
REGION VII

MAY 17 11 28 AM '85

Kenneth L. Neff
Executive Director
Nebraska Foundation for Medical Care, Inc.
Suite 801, CTU Building
1221 N Street
Lincoln, Nebraska 68508

May 14, 1985

Re: PRO Contract HCFA 500-84-0529

Dear Mr. Neff:

This letter is in response to your communications of January 29, and April 3, 1985 concerning an increase in workload due to Program Directive #5 and IM-85-2.

Your concerns have been reviewed by the Program Office staff and in their opinion the slight increase in review activity will be offset by the decrease in workload as a result of modifications in APM and required medical review activities of the PRO. Revisions to the APM activities are scheduled to be issued soon. It should be noted that as of this time we have not released two quarters of APM activity, which in and of itself has significantly reduced the individual PRO's workload and costs to date.

If a PRO can substantiate that the shift in workload results in increased efforts, and therefore additional funds are needed, the PRO should submit a budget with justification to the contracting officer in order to get a fair and equitable adjustment to the fixed price amount of the contract.

If we can be of further assistance, please let me know.

Sincerely,

Philip J. Gomez

Philip J. Gomez
Contract Specialist

cc: Ben Gruber, PRO Project Officer

Rcd
5/28

Reporting Date: 5 / 23 / 85

NDHCRI INCIDENCE REPORT TO REGIONAL OFFICE

Patient Name: ____________ HIC NO.: ____________ Age: ___

Admit Date: ___/___/ __ Hosp. Name ____________ MPR No.35-_____

Physician Name: ____________ M.D. License No.: ____________

Reviewer Numbers: R.S. ____ P.A. ____ Reviewed: 5 / 1 / 85

Incidence Type:

x A. Readmission Subsequent to a Pre-mature Discharge
___B. Transfer Of a Questionable Nature
___C. Hospital Initiated Denial Not Reported on Monthly List
___D. Inappropriate Hosp. Init. Den. Issued Prior to DRG ALOS

(Narrative description of the problem or discrepancy using as accurate direct language as possible. Use physicians orders and physician advisor notes for quotations where possible.)

This patient was initially admitted to the [redacted] on 2/7/85 and was subsequently readmitted on 2/10/85. On the first admission the patient presented with symptoms of "extreme dizziness and severe weakness". The patient stated that his blood pressure had been exceedingly high at home. The only treatment the patient received was his blood pressure and pulse monitored q.i.d. The patient was discharged 2/9/85 and readmitted on 2/10/85 with weakness on his right side, headache, and a feeling of instability. It is documented within the medical record for the second admission that "I have talked to [redacted] about Medicare and told him he cannot stay any longer and is being discharged." Again, the patient was treated with vitals being monitored. q.i.d. It was reviewed and referred to a Physician Advisor as a questionable premature discharge. The physician advisor's comments follow: "This was a premature discharge involving the first admission. Two admissions should not have occurred."

Distribution - Type	A B C D
NDHCRI	A B C D
Regional Office	A B C D
Hospital	A B C D
Attending Physician	A B C D
Fiscal Intermediary	D
Patient	D

DEPARTMENT OF HEALTH & HU

Office of the Secretary

Memorandum

Date MAY 24 1985

From Thomas E. Herrman, Attorn
Inspector General Divisio

Subject Delegation of Authority Under Section 1886(f)(2) of the Social Security Act

To Don Nicholson
Assistant Inspector General
for Health Financing Integrity

I have reviewed your proposal to request the Secretary to delegate her authority under section 1886(f)(2) of the Social Security Act. This provision was enacted as a part of the Social Security Amendments of 1983 (Pub. L. 98-21) which established the new Medicare Prospective Payment System for inpatient hospital services. Section 1886(f)(2) authorizes the Secretary to make determinations, based on information received from utilization and quality control peer review organizations (PROs), that a hospital has taken action "to circumvent the (prospective) payment" system resulting in unnecessary hospital admissions or other inappropriate medical practices with respect to Medicare beneficiaries. Once such a determination is made, the Secretary may deny payment for inpatient hospital services, or require the hospital to take corrective measures.

I have revised the wording of the proposed delegation of authority in order to accurately reflect the statutory authority vested with the Secretary, as well as to clearly describe the powers delegated to the Inspector General. I recommend that the proposed Justification for the delegation be revised accordingly. Specifically,

1) Once the Secretary has made a determination under section 1886(f)(2) of the Act, the statute gives the Secretary the authority to either deny payment for inpatient hospital services or order corrective action. The authority to deny reimbursement or order the withholding of payment under Medicare Part A must be referenced in both the Delegation and Justification.

2) The Justification references the Interim Final Regulations published by the Department on September 1, 1983. However, these have been superceded by the Final Rule published on January 3, 1984 (49 Fed Reg. 234). The final regulation makes no reference to section 1862(d), as is indicated in the Justification. Rather, the regulation provides that certain "practices that have the effect of circumventing the prospective payment system, will be referred to the Office of Inspector General for a determination in accordance with section

1866(b)(2) of the Act." (§ 405.472(e)(3)). The Justification should be revised accordingly. Furthermore, it should be recognized that only the authority contained in sections 1866(b)(2)(D),(E) and (F) have been delegated to the Inspector General. The authorities set forth in sections 1866(b)(2)(A),(B),(C), and (G) remain vested with HCFA. (See Delegation of Authority to the Inspector General, dated April 18, 1983)

3) Most importantly, the Justification states "that (now that) PROs are about to be established, it is appropriate to fully implement the authority contained in section 1886(f)(2) ..." However, the procedures governing the implementation of section 1886(f)(2) have not been included in the Department's proposed regulations for imposing sanctions based on the recommendations of PROs (49 Fed. Reg. 15234, April 18, 1984). In view of the fact that a Secretarial determination under section 1886(f)(2) must be based on the findings of a PRO, it would appear appropriate for the PRO sanction regulations (42 CFR Part 474) to specify the procedures governing determinations and actions taken under section 1886(f)(2) of the Act.

Finally, we presume that HCFA's concurrence to the proposed delegation has been obtained. If you have any questions, please call me.

Attachment

MEMORANDUM TO: INSPECTOR GENERAL

SUBJECT: Delegation of Authority Under Title XVIII of the Social Security Act, as Amended, Pertaining to the Control of Fraud or Abuse in the Medicare Program.

Under the authority vested in me by the Social Security Act, as amended, I hereby delegate to you, with the authority to redelegate and to authorize further redelegation, the authority under section 1886(f)(2) of the Act to determine that a hospital has taken action in order to circumvent the Department's Medicare Prospective Payment System, resulting in the unnecessary admission of Medicare beneficiaries, or other inappropriate medical or other practices with respect to such individuals. Further delegated is the authority to order the withholding of payment under Part A of Medicare because of such a determination, as well as to require a hospital to take corrective action deemed necessary to prevent or correct identified practices which are inappropriate.

This delegation is effective immediately.

________________ ____________________________

Date

Margaret M. Heckler

Secretary

[illegible] File No 2

May 29, 1985

Mohammed N. Akhter, M.D.
Executive Vice President
and Medical Director
Missouri Patient Care Review Foundation
1605 C Northeast Drive
Jefferson City, Missouri 65101

Dear Dr. Akhter:

I received a copy of Tom Morgan's May 23 letter to William Tate (Correspondence No. 67) concerning IM 85-2 and IM 85-3. I would like to reemphasize that, while your contract does provide for the requesting of a contract modification in the event HCFA instructions require an increase in work to be performed under your contract, you are expected to implement the required changes pending a final decision on any necessary contract modifications. Therefore, I expect that the Foundation will continue to implement all requirements of IM 85-2 and IM 85-3 without delay, notwithstanding your need to conduct an analysis of additional resources.

Sincerely yours,

Gregory A. Lear, Chief
Medical Review Branch
Division of Health Standards and Quality

cc: Tony Tirone-MROB
Joe Simmons-Cont. Spec.

DHSQ:MRB:GAL:ir/5-29-85

MRB Lear 5/29

The Peer Review Organization of New Jersey, Inc.

Central Division
Jefferson Building - East
330 Milltown Road
East Brunswick, NJ 08816
(201) 238-5570

Southern Division
1940 Route 70
Cherry Hill,
New Jersey 08003
(609) 424-7433

June 18, 1985

JUN 1985
RECEIVED

Mr. Samuel Ford
Project Officer
HCFA - Region II
Federal Building
26 Federal Plaza
Room #3804
New York, New York 10278

Dear Mr. Ford:

As a follow-up to your recent PROMPTS visit, we are enclosing a revised Quality Objective III. We believe, that the methodology described in implementing this objective will also impact positively on our other Quality Objectives.

It is my understanding that the Central Office was requesting methods of performing concurrent review to prevent premature discharges. The methodology that we will be utilizing for this objective would serve to prevent premature discharges as well as reduce the mortality rate.

The estimated cost involved in utilizing hospital nursing personnel to assure an appropriate concurrent intervention process would be approximately $110,000.

We obviously did not anticipate this cost in our original budget submission. If there is any way we might be able to receive additional funding to accomplish this process it would be greatly appreciated.

Mr. Samuel Ford
Project Officer
HCFA - Region II
Page Two

Thank you for any consideration you may give this matter. If you have any questions regarding this objective, please do not hesitate to contact either D.D. Griffith, M.D., at Central Division or Ms. Virginia Meisner at Southern Division.

Sincerely yours,

Martin Margolies

Martin P. Margolies
Executive Vice President

MPM/ek
Enclosure

QUALITY OBJECTIVE III

Introduction

The following proposal is being submitted as the basis for requesting a contract modification to replace the original Quality Objective III with the topic of Congestive Heart Failure.

The goal of this objective is to reduce avoidable death. This organization is proposing a reduction in deaths due to Congestive Heart Failure of 2.0%, an anticipated reduction of 46 deaths per annum based on CY1983 statewide data.

Much consideration was given to the recognition that Congestive Heart Failure will be the topic for each of the first three quality objectives during the PRO of New Jersey, Inc., contract period. However, even after further profile analysis of available statewide data related to mortality, physician feeling remained strong that a reduction in CHF deaths appears to be achievable and should be attempted. Additionally, given that Congestive Heart Failure consistently accounts for the greatest number of Medicare discharges over the years, it is believed that intense focusing on this one category will achieve significant impact in both morbidity/mortality and improved care for a large proportion of the Medicare population.

As described more fully below, this organization is proposing what is felt to be an innovative methodology to achieve its goals. Briefly, this includes using a Concurrent Quality Review Study methodology which has had some success in one of the former PSROs in New Jersey. This method emphasizes concurrent intervention by PRO of New Jersey physicians on all cases reviewed, while the patient is in the hospital undergoing treatment.

By its nature, intervention under this methodology will impact on avoiding potential readmissions resulting from sub-standard care, improving the quality of services rendered and reducing the risk of death, in essence, the goals of the first three quality objectives. Therefore, it was essential to consider the measurability of each objective and the stated reductions.

In order to adequately demonstrate the impact achieved, this organization believes the results of review can be tracked separately and attributed to the appropriate objective by carefully managing the data system and reporting the counts as follows:

1. Isolating and counting the number of deaths to demonstrate impact for Quality Objective III. Then counting the readmissions in which death occurred as a separate issue in order not to lose track of total readmission incidence.

2. Isolating and counting the number of readmissions without death to demonstrate impact for Quality Objective Ia.

3. Of the records remaining (i.e., excluding deaths and readmissions), isolating and counting the cases where criteria, reflective of providing necessary services, were met to demonstrate impact for Quality Objective II. Again, keeping the broad picture in mind, this count can also be made in the death and readmission categories as an item apart from impact documentation.

Incidental to, but because of the effect of intensifying review efforts to improve care and reduce potentially avoidable death, it is believed utilization with regard to admission volume will also be affected. Although impact on admission rates will not be counted as part of this objective, it is worthy of note because of the significant proportion of total Medicare population that CHF represents.

Finally, this organization is undertaking a developmental objective which will focus on the quality of nursing care and management of patients in congestive failure. Since good nursing care is crucial in carrying out physician treatment orders, observing patient response to treatment and intervening appropriately on untoward events, it is felt that achieving the goal of this objective will be significantly enhanced.

In summary, because of the scope of the objective, by virtue of the population affected, and, the potential for innovatively achieving the highest optimal outcome for individual patients, it is the desire of the physicians of this organization to keep Congestive Heart Failure as the topic for quality objectives one, two and three. With this in mind, the following detailed proposal is respectfully submitted.

OBJECTIVE STATEMENT: Reduce the Medicare statewide death rate for Congestive Heart Failure from 13.2% to 13.0% which will result in 46 less deaths than would be expected to occur, a reduction of 2.0%.

Problem Identification/Verification

The care and treatment for Congestive Heart Failure (CHF) has been an ongoing topic of discussion among PRO of New Jersey physicians. The concern is partially reflected in the selection of CHF as the topic for the first two quality objectives under the PRO contract.

In terms of admission volume, CHF persistently ranks number one for the Medicare population in New Jersey. In reporting the results of his "Small Area Analysis" in a number of states as well as some statistical review of national figures, John Wennberg, M.D., lists CHF among those medical diagnoses evidencing high variation in practice.

In New Jersey, the statewide percent of Medicare CHF deaths was 13.3 in 1982 and 13.2 in 1983. At the time of conducting the areawide study described below, the statewide percent of Medicare CHF deaths was reportedly 13.1 for the calendar year 1980, which seems to indicate little change over time.

Undoubtedly, CHF is a complex phenomenon with outcome often dependent on the etiology of the underlying disease. Some cases with coronary artery or valvular heart disease are amenable to surgery with an expectation of good outcome. In cases with severe Cardiomyopathy, CHF is a progressive disorder ultimately leading to death even with well-managed vigorous treatment. Nevertheless, there is clinical consensus that incomplete treatment of CHF can lead to complications which may have severe consequence including death. It is believed that, by reducing the complications in the treatment of CHF and by initiating timely and appropriate actions when they do occur, death may be avoided in a number of cases.

Because of the significance of this objective and the need for control in the early stages of treatment, a concurrent review methodology with the ability to intervene promptly is essential. This concurrent methodology was used with apparent impact in a quality review study on CHF discharges for December 1982 through February 1983, performed in twenty hospitals under the jurisdiction of a former New Jersey PSRO. Table A reflects the direction and degree of change experienced by this PSRO over time.

TABLE A - MEDICARE CHF DISCHARGES, PSRO A

	TIMEFRAME	# DISCHARGES	# DEATH	% DEATH
Baseline:	Jan - June 1981	2,127	304	14.3
	Jan - June 1982	1,945	273	14.0
	Jan - June 1983	2,135	278	13.0
	Jan - June 1984	1,825	222	12.2

Data Source: PHDDS
CHF Codes: 428.0; 428.1; 428.9

As well as could be determined by this PSRO, at the time of setting their objective the statewide percent of Medicare CHF death was 13.1 for CY1980. For the same timeframe this PSROs PHDDS data showed its areawide percent of Medicare CHF deaths was 14.0. Table B displays the current status for this former PSRO area in relation to available statewide data for 1982 and 1983.

TABLE B - MEDICARE CHF DISCHARGES

	# DISCHARGES	# DEATH	% DEATH
Calendar Year 1982			
Statewide	17,418	2,319	13.3
PSRO-A	4,147	527	12.7
State excluding PSRO-A	13,271	1,792	13.4
Calendar Year 1983			
Statewide	17,461	2,311	13.2
PSRO-A	3,693	462	12.5
State excluding PSRO-A	13,768	1,849	13.4

Data Source: PHDDS
CHF Codes: 428.0; 428.1; 428.9

As can be seen, there has been a decrease for PSRO-A in both the number and percent of death. When PSRO-A data is excluded from statewide figures, it appears there has been little change in these data elements for the state.

Following completion of the above noted concurrent phase of the study, a retrospective study was performed by the PSRO on a sample of cases drawn from the same time frame. In analyzing the results, the PSRO physician reviewers observed an incidental finding of wide variations among hospitals in the incidence of CHF complications and the services provided.

Prior to setting this proposed PRO objective, PRO of New Jersey physician review was performed on a sample of the cases in the original PSRO study and in which death occurred in order to re-evaluate this finding. Forty-eight charts were selected from seven hospitals. Of these, it was determined that three deaths might have been avoidable with more aggressive management of the complications, i.e., arrythmia, hypokalemia and high digitalis levels.

PRO of New Jersey physicians are of the opinion that the 2.0% reduction in mortality rate which was achieved by the above-noted PSRO is attainable on a statewide basis.

An important exogenous factor that must be noted is that, as a result of aggressive utilization review, the patients who are admitted will have a more severe stage of illness. This will tend to increase the mortality rate and make it difficult to attain a greater impact in this objective.

Baseline Measurements and Desired Outcomes

The data source used for the baseline measurement and to project future volume and impact was the statewide PHDDS for calendar years 1982 and 1983. In keeping with all of the objectives, calendar year 1983 will serve as the baseline against which impact for the contract period will be measured.

The 1983 baseline will also be the statistical base upon which milestone target reductions will be projected. However, the data source for tracking progress in meeting the projected quarterly milestones will be the claims data submitted to this organization by Medicare fiscal intermediaries. Since this is only available for those hospital claims submitted to the FI, data will not be complete in any given quarter but will need to be updated on an ongoing basis in the quarterly reports.

The table below displays the baseline data and projected impact period reductions. As used here, "problem" refers to the number of deaths.

		POPULATION SUBJECT TO THE PROBLEM	# CASES WITH THE PROBLEM	NUMBER REDUCTION	% CASES WITH THE PROBLEM
Baseline:	CY1983	17,461	2,311		13.2
Impact:	CY1985	17,461	2,265	46	13.0
	CY1986	17,461	2,265	46	13.0
Contract	Period	34,922	4,530	92	13.0

Criteria

Day of care criteria have been developed for use by review coordinators to concurrently screen cases from the day of admission through the day of discharge (Attachment I). Criteria for screening cases to assess the quality of care and services provided have already been approved by HCFA (Attachment II).*

*[Not provided by HCFA.]

DEPARTMENT OF HEALTH & HUMAN SERVICES

Doris!

Health Care Financing Administration

fe:

6325 Security Boulevard [illegible]
Baltimore, MD 21207 [illegible]

JUN 2 0 1985

RECEIVED
HSQ BOSTON
JUN 26 '85

The Honorable Christopher J. Dodd
United States Senate
Washington, D.C. 20510

Dear Senator Dodd:

This is in response to your inquiry of May 7 on behalf of your constituent, James M. Streeto, M.D. Dr. Streeto wrote to you concerning medical review conducted by the Connecticut Peer Review Organization, Inc., the Utilization and Quality Control Peer Review Organization (PRO) for the State of Connecticut.

Dr. Streeto is concerned that, in Connecticut, non-physicians are making some denial determinations and that attending physicians are not being given the opportunity to discuss proposed denials with a PRO physician.

I was greatly concerned to learn of Dr. Streeto's claims. A member of my staff contacted our Regional Office in Boston and obtained the following information. First, in Connecticut, as in all other PRO areas, denial determinations are made only by a PRO physician. Non-physicians review cases using professionally developed screening criteria selected by physicians in Connecticut. Any case that does not meet these screening criteria is referred to a PRO physician for review. Second, attending physicians are contacted prior to issuance of an initial denial determination and are asked to submit comments or additional information in writing to the PRO. However, the PRO has not been giving the attending physician an opportunity to discuss the case directly with a PRO physician. This is counter to our policy and we will see that the PRO changes its procedures immediately to do so. Our Boston Regional Office will be closely monitoring the PRO to assure that it is complying with all review procedures.

Thank you for bringing these issues to my attention.

Sincerely yours,

Philip Nathanson
Director
Health Standards and Quality Bureau

cc: Lawrence Osborn, M.D., ARA ✓
Region I

MEMO TO: Chairmen, Hospital Quality Assurance

FROM: Robert E. Newhouse, M.D., Chairman, Quality Review Committee

RE: Quality Review Study I(Readmissions within Seven Days)

DATE: June 24, 1985 MEMO # 85-6

As you know, Health Care Review Inc. as the PRO under the Prospective Payment System, has implemented five studies which address the quality of care delivered to Medicare beneficiaries in short term acute care hospitals in Rhode Island. This memorandum concerns Quality Objective I which aims to reduce readmissions within seven calendar days due to premature discharge from a previous admission.

As indicated in previous correspondence, all readmissions within seven days are reviewed by a Health Care Review Inc. review coordinator. Each case thought to be a premature discharge on the first admission is referred to a Health Care Review Inc. physician reviewer. All cases of premature discharge are then referred to the Quality Review Department. Since August 1, 1984 the Quality Review Department has been assessing all such cases on an ongoing basis, in an attempt to identify patterns of substandard care which might have been responsible for patients' subsequent readmission to the hospital.

This analysis revealed the following premature discharge indicators which may serve as clues that patients falling into these categories do not always do well following discharge and may require readmission to the hospital.

1. Clinical problems (e.g. vital signs unstable, current complaints not resolved or controlled, and known or suspected problems not worked up).

2. Laboratory related problems (e.g. laboratory or other tests incomplete, acute disease process with test results not received by time of discharge, and patient discharged with abnormal lab results without further work-up).

3. Medication problems (e.g. therapeutic medication range not achieved or new medication not regulated).

4. Consultant recommendations not acknowledged or followed.

5. Prescribed diet not adequately tolerated (including nasogastric and gastrostomy tube feedings).

6. Bladder problems (e.g. signs and symptoms of urinary retention, hematuria etc.)

7. Bowel problems (e.g. lack of adequate bowel function prior to discharge).

8. Administrative problems (e.g. planned readmission for follow-up procedure/surgery and poor or absent discharge planning necessitating readmission).

9. Patient problem (e.g. patient desired discharge).

Enclosed you will also find statistics for the total number of readmissions within seven days, and the number of premature discharge for each Rhode Island hospital.

I hope that the above information will be helpful to you in assessing whether or not certain patients at your hospital are ready for discharge. I recognize that there are certain situations which are beyond your control; for instance, some patients might wish to go home to await forthcoming surgery.

If you have any further questions or require additional information please feel free to contact me or Ms. Marianne Raimondo, Director Quality Assurance, Health Care Review Inc.

We continue to share your efforts and concerns in providing the best quality of care possible for the beneficiaries of Medicare.

jh

cc: Chief UR Coordinators

Total # Readmissions within 7 days and Premature Discharge by Hospitals

R=total #7day readmissions
P=Premt. Disch.

CONFIDENTIAL

	Aug. '84 #R	#P	Sept. '84 #R	#P	Oct.'84 #R	#P	Nov. '84 #R	#P	Dec. '84 #R	#P	Jan. '85 #R	#P	Feb.'85 #R	#P	Mar.'85 #R	#P	April'85 #R	#P	May'85 #R	#P	Total # Re-adm.	Total# pre-dis-ch.	%of pre. disch.
Small Hospitals																							
A	11	-	6	-	15	-	7	-	13	-	13	1	9	-	4	-	6	-	6	-	90	1	1.1%
B	9	-	5	-	7	-	5	-	5	-	8	1	7	-	7	-	5	-	6	-	64	1	1.6%
C	2	-	-	-	4	-	2	-	1	-	-	-	-	-	3	-	-	-	-	-	12	0	0%
D	8	-	8	-	7	-	8	-	5	-	15	-	5	1	10	-	15	1	6	1	87	3	3.4%
E	-	-	3	-	2	-	4	-	-	-	2	-	[illegible]	-	3	-	3	-	3	-	21	0	0%
Med. Hospitals																							
F	18	1	12	2	10	2	19	-	7	-	[illegible]	[illegible]	12	1	14	-	21	-	14	2	145	9	6.2%
G	10	-	8	-	7	1	6	-	9	-	[illegible]	1	4	-	7	1	9	-	8	-	77	3	3.9%
H	13	-	13	-	3	-	13	-	4	(1)	9	-	6	2	26	-	12	-	13	-	112	3	2.7%
I	14	-	5	-	-	-	2	1	[illegible]	-	4	1	9	-	5	1	11	-	-	-	57	3	5.3%
J	7	1	4	-	4	-	3	[illegible]	[illegible]	-	7	-	14	-	7	-	7	-	17	-	74	1	1.4%
K	17	-	15	-	9	-	11	[illegible]	12	-	13	1	13	-	19	3	20	* (1)	16	-	145	3 4	3.4% [illegible] %
L	6	-	-	-	-	-	-	-	-	-	1	-	-	-	-	-	-	-	-	-	7	0	0%
Large total both	17		13		4		11		11		20		28		21		26		27				
M	11		8	-	3		4	-	4	-	7	-	15		10	-	15		12		178	5	2.8%
N	6	1	5	-	1	1	7	-	7	-	13	-	13	1	11	-	11	1	15	1			
O	22	-	29	-	17	1	15	-	11	-	26	2	27	2	13	-	18	2	32	1	210	8	3.8%
TOTAL	154	3	121	2	89	5	106	1	89	1	145	8	135	7	139	5	153	5 4	148	5	1,279	42 41	

* [illegible] [illegible] on this [illegible]

3

Maine:
Objectives

fc:

Health Care Review Inc.

The Weld Building
345 Blackstone Boulevard
Providence, Rhode Island 02906
Tel. (401) 331-6661

Quality Health Care 1973

Edward J Lynch
Executive Vice President

June 27, 1985

Mr. Linwood Parsons
Project Officer
Health Standards & Quality Bureau
Health Care Financing Administration
Regional Office
John F. Kennedy Federal Building
Government Center
Boston, Mass. 02203

Dear Mr. Parsons:

Based on the recommendations you proposed in our telephone conversation on June 24, 1985 I have enclosed your revisions to the Quality Objectives Health Care Review Inc updated on June 3, 1985 for the state of Maine.

If you have questions concerning these revisions or require additional information please contact me.

Sincerely yours,
Marianne Raimondo
Marianne Raimondo
Director Quality Assurance

MR:jh

MAINE QUALITY OBJECTIVE I
REDUCE READMISSIONS WITHIN SEVEN CALENDAR DAYS DUE TO PREMATURE DISCHARGE

COMMENT ON CRITERIA:

Every readmission within seven days is reviewed by a nurse coordinator utilizing Hospital Level of Care and Interqual criteria. Specific indicators, developed by Maine physicians and staff are then applied to cases thought to be premature discharges

PREMATURE DISCHARGE INDICATORS FOR FIRST ADMISSION

1. Vital signs not stable:
    a. Elevated termperature not stable 24° prior to discharge
    b. Oral temperature below 100°/37.7
2. Laboratory test or other studies incomplete
3. Test results not recieved--acute process
4. Signs/symptoms of urinary retention +120cc
5. New medication not regulated or discharge medication inappropriate
6. Current complaints not resolved or controlled
7. Known or suspected problem not worked-up
8. Consultant recommendations not acknowledged/followed
9. Discharged for readmission for follow-up surgery/procedure
10. Discharged for readmission for follow-up surgery-readmitt as emergency

MAINE QUALITY OBJECTIVE I REVISED

Reduce Readmissions within Seven Calendar Days Due to Premature Discharge

I. B. Identification/Verification/Validation and Physician Involvement

The Medical Review Activity Report for the time periods of October through December 1983, and January through April, 1984 were obtained for the State of Maine. These reports were prepared by Maine Blue Cross/Blue Shield, the fiscal intermediary. The data indicated 277 readmissions from October 1983 through April 1984.

The reports however, did not indicate that any cases were denied or referred to Regional Office as a premature discharge. This may reflect the type of review performed by the Maine Fiscal Intermediary rather than the absence of problems with premature discharges based on its experience in review of readmissions within seven days.

As the PRO in Maine, Health Care Review Inc. will identify readmissions resulting from substandard care during the previous admission.

Through review performed on readmissions between November 1984 and January 1984, 21 premature discharges were identified. Monitoring of premature discharge patterns revealed common indicators for premature discharge which are attached.

II. A. Baseline Measurement

Readmissions within 7 Days	Number Premature Discharges
Nov., 1984 - Jan., 1985 = 181	21

B. Desired Outcome:

Health Care Review Inc. will reduce the number of readmissions within seven (7) calendar days by 42 cases.

Projected 7 Day Readmissions Nov.1984-Nov.1986	Projected Premature Discharges Nov.1984-Nov. 1986	Desired Outcome 7 Day Readmissions Nov.1984-Nov. 1986
1,488	168	1,406

Desired Outcome Premature Discharge Nov.1984-Nov. 1986
126

REVISION

Maine Quality Objective I - Reduce Readmissions within Seven Calendar Days Due to Premature Discharge

REVISED METHODOLOGY - Every Medicare patient readmitted within seven days will be reviewed by a Health Care Review Inc. Utilization Review Coordinator. (Registered Nurse) The nurse coordinators utilize Hospital Level of Care Criteria, InterQual and other system specific criteria applicable to each readmission within seven days. Each case presenting a question of medical necessity or premature discharge as a result of substandard care on the prior admission will be referred to a Health Care Review Inc. Physician Reviewer. If, after review of both admissions, the physician reviewer determines that the second admission is a result of premature discharge from the first admission, the case will be referred to the Health Care Review Inc. Quality Review Department. This referral will be accompanied by a copy of the nurse coordinator's worksheet and the physician reviewer's rationale for determining the patient to be prematurely discharged.

A copy of the physician reviewer's rationale is also provided to the attending physician responsible for the first admission alerting him/her to the fact that the care provided during that admission was not considered complete at the time of discharge.

Each premature discharge referred to the Quality Review Department is then assessed and recorded. Data is collected for each case including: Hospital, Medical Record Number, Attending and Operating physician, Admission diagnosis, Principal diagnosis, Admit date, Discharge date, Admit and discharge date of first admission, date of review by Health Care Review Inc. and premature discharge rationale.

Each premature discharge is assigned a "Premature Discharge Indicator" which places each case in a particular category of premature discharge.

The Quality Review physicians and coordinators will continuously analyze this date to identify patterns of premature discharge.

Maine hospitals will be informed of the results of this analysis and the specific types of cases being prematurely discharged at each facility.

Hospitals will then be educated as to appropriate discharge practices for such cases. If hospitals are continuing to discharge patients prematurely, indicating substandard care is being delivered, then sanctions will be issued.

Health Care Review Inc. will also analyze data for all readmissions within seven days to identify patterns of potential problems with premature discharges. Also, history data, once provided by the FI in Maine will be analyzed to observe trends in readmissions and changes in these trends.

Hospitals will be notified of the results of this analysis and of the findings of Health Care Review Inc. record review. Patterns of premature discharge and substandard care will be highlighted. Hospitals will be asked to propose corrective action plans if necessary.

The results of the data analysis will be utilized in establishing specific quality studies in the realm of readmission patterns pertaining to select hospitals, physicians, diagnoses, or procedures.

MILESTONE CHART

Quality Objective I

Reduce Readmissions within Seven Calendar Days Due to Premature Discharge

TASK	PERSONNEL	QTR INITIATED	QTR COMPLETED	ESTIMATED IMPACT
Premature discharge referred to Quality Dept.	Health Care Review Inc. review coordinators	1st. 1985 ongoing	1st. 1987	
Monitoring of premature discharges-data collection	Quality Review and Data staff	1st. 1985 ongoing	1st. 1987	
Data analysis of all readmission data	Quality Review and Data staff	3rd. 1985	3rd. 1985	5 cases
Distribution of findings to hospitals with recommendations	Quality Review Committee physicians and Quality Review staff	3rd. 1985	4th. 1985	5 cases
Assess criteria methodology	Quality Review Committee and staff	3rd. 1985	4th. 1985	
Monitoring of impact of Health Care Review Inc. Recommendations	Quality Review staff	1st. 1986	2nd. 1986	5 cases
Individual hospitals and physicians notified-sanctions issued if necessary	Chairman Quality Review Committee	2nd. 1986	2nd. 1986	5 cases
Focused review initiated of problem areas	Quality Review staff	3rd. 1986 ongoing	3rd. 1986	
Hospitals notified of findings-educational session	Quality Review Committee and staff	4th. 1986	4th. 1986	

TASK	PERSONNEL	QTR INITIATED	QTR COMPLETED	ESTIMATED IMPACT
Hospitals requested to propose action	Hospital staff	1st. 1987	1st. 1987	10 cases
Monitoring of hospital action	Quality Review staff	2nd. 1987	2nd. 1987	
Sanctions iissued if necessary	Quality Review Committee	3rd. 1987	3rd. 1987	10 cases

MAINE QUALITY OBJECTIVE II
PROPHYLACTIC ANTIBIOTIC USE IN SURGERY

III. Description of Review Methodology and Personnel Involved:

A. Criteria:

Criteria for the timing and duration of antibiotic prophylaxis, approved by the Maine Quality Committee, is attached.

ANTIBIOTIC STUDY

A. Surgical Procedures Requiring Prophylaxis:

High risk Cholecystectomy
ABD. & Vag. Hysterectomy
THR & TKR

B. Timing of Antibiotic Prophylaxis:

Up to 4 hours prior to surgery, including at induction of anesthesia - acceptable
Intra-op - not acceptable
Started post-op - not acceptable
Pre-op only - acceptable

C. Duration of Antibiotic Prophylaxis:

Up to 72 hours following surgery - acceptable

B. Timing of Review and Personnel Conducting Review:

In January, 1985, Medicare discharges from Maine hospitals undergoing any of the five study procedures will be identified from current PATbill data provided by Maine Blue Cross. Review of these records will commence in February, 1985, and data will be collected relative to the use of antibiotics including type of drug, dosage, duration, etc.

Selection of cases, subsequent review, and data collection will be ongoing as PATbill/UNIbill data is supplied by the FI. Criteria developed by Maine physicians will be applied to the data to assess the rate of inappropriate antibiotic prophylaxis in Maine hospitals and to pinpoint problem areas. Questionable cases will be reviewed by physician consultants

Data analysis will than be performed to measure the extent of inappropriate antibiotic prophylaxis.

A summary of study findings along with individual and overall hospital recommendations will be developed by the physicians of the Quality Review Committee and will be distributed to the participating Maine hospials.

An educational session will be developed and presented by the Health Care Review Inc. Quality Review Committee and Consultants during the fourth quarter 1985. The committee has considered the development of and educational pamphlet or posters for use in Operating Rooms. Because the use of antibiotics is an ever changing field, the educational session will address the currently acceptable medical practice of prophylactic antibiotic use in surgery--namely, indications for use of an antibiotic, choice of antibiotic, dosage, timing and duration.

C. Monitoring of Objective Methodology:

The Quality Review Committee physicians and Quality Review and the Data Department staff will initiate a follow-up study during third quarter 1986. The same physician established criteria applied during the initial study will be utilized. The effect of educational intervention on antibiotic prophylaxis surgery will be assessed.

Prophylactic Antibiotic Use In Surgery

II. A. Baseline Measurement Procedure

Procedure	#Disch.Nov.'84-Mar.'85	Projected Disch.[1] contract Interval	#Inappropriate Prophylaxis
Cholecystectomy	255	1,244	423
Hysterectomy	88	176	60
Total Hip Replacment	150	720	245
Total Knee Replacement	94	460	156
	587	2,600	844

B. Desired Outcome

Health Care Review Inc. will reduce inappropriate antibiotic prophylaxis by 50%.

Procedure	Projected Dischs. Contract Interval	#Inappropriate Prophylaxis
Cholecystectomy	1,244	212
Hysterectomy	176	30
Total Hip Replacement	720	123
Total Knee Replacement	460	78
	2,600	443

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[1] Projected based on Nov. 1984-March 1985 data

MILESTONE CHART

Quality Objective II

Antibiotic Prophylaxis in Surgery

TASK	PERSONNEL RESPONSIBLE	DATE INITIATED	DATE COMPLETED	ESTIMATED IMPACT
Criteria and data collection scheme developed	Maine Quality Review Committee (physician) and consultants	Jan. 1985	Feb. 1985	
Study sample selected	Quality Review and Data staff	Feb. 1985	ongoing	
Record Review initial audit	Quality Review nurse coordinators	Feb. 1985	Sept. 1985	50 cases
Data Analysis	Quality Review Committee, Quality Review staff and Data staff	3Q 1985	3Q 1985	
Summary and recommendations distributed to hospitals	Quality Review Committee and staff	3Q 1985	4Q 1985	50 cases
Educational Intervention	Committee physicians and staff and consultants	4Q 1985	1Q 1986	50 cases
Reaudit	Quality Review coodinators	2Q 1986	3Q 1986	100 cases
Data Analysis	Quality Review Committee staff and data staff	3Q 1986	3Q 1986	100 cases
Distribution of conclusions recommendations	Quality Review Committee and staff	3Q 1986	3Q 1986	90 cases

MAINE QUALITY OBJECTIVE III REVISED

Mortality Associated with Pulmonary Embolism

I. A. Problem Description

Health Care Review Inc. investigated the association between pulmonary embolism and deep vein thrombosis by analyzing 1984 data. The data revealed 635 cases with a documented diagnosis of pulmonary embolism and deep vein thrombosis. Of these patients, there were 74 deaths, representing a case fatality rate of 11%.. Pulmonary embolism and deep vein thrombosis accounted for 2.5% of total deaths (2971 deaths) in 1984.

B. Identification/Validation/Verification and Physician Involvement

The physicians of the Health Care Review Inc. Quality Review Committee concur that mortality associated with pulmonary embolism is a well-known and widespread phenomenon. The physicians also concur with published literature that there is an intimate but unpredictable association between thrombosis in the deep peripheral veins and death from embolization of these thrombi to the pulmonary arteries,[1] that is, 95% of pulmonary emboli originate in the leg or pelvic veins.[2]

The physicians, therefore, requested statistics on all Maine Medicare patients discharged during 1984 with documented pulmonary embolism and/or lower extremity deep venous thrombosis (DVT). Analysis of this data indicated Medicare patients with a principal or secondary diagnosis of pulmonary embolism, deep venous thrombosis, or both, representing a high risk group for death, of these 635 patients 74 or 11% expired.

The following observations about pulmonary embolism have prompted the Quality Review Committee physicians to concur that a study should be performed in the interest of the elderly population.

Age Factor

1. Patients more than 60 years old have an increased incidence of deep venous thrombosis compared to those in the younger age groups.[1]
2. Venous thromboembolism (combined term for deep venous thrombosis and pulmonary embolism), is prone to occur among the elderly, among persons immobilized for any cause and in individuals having a previous history of venous thrombosis.[2]

MAINE QUALITY OBJECTIVE III

Mortality Associated with Pulmonary Embolism

II. A. **Baseline Measurement:**

#Cases with PE/DVT 1984	#Deaths Among Patients with PE/DVT
635	74 (11%)

B. **Desired Outcome:**

Health Care Review Inc. will reduce the mortality among patients with pulmonary embolism from 11% to 9% by Nov. 1, 1986, from 148 cases to 114 cases.

Projected # cases With PE/DVT	#Deaths Among Patients with PE/DVT	
Contract Interval	Without Intervention	With Intervention
1,270	148	114

QUALITY OBJECTIVE III

Mortality Associated with Pulmonary Embolism

II. Methodology

The focus of Health Care Review Inc.'s study on mortality associated with pulmonary embolism is prevention of PE and DVT for high risk patients.

Medicare discharges with a documented diagnosis of pulmonary embolism or deep vein thrombosis will be selected from PATbill data submitted by the Maine FI. The medical records of these patients will be reviewed during the first three quarters of 1985 by Health Care Review Inc. nurse coordinators. Data will be collected on risk factors for PE/DVT, such as obesity, smoking, surgery, acute M.I., etc. Data will also be collected on prophylactic measures taken, both mechanical methods and anti-coagulation therapy.

The data will be developed during the fourth quarter of 1985 by the Director of Quality Assurance and the data staff to identify the risk factors among Maine patients with PE/DVT and to assess whether prophylactic measures are being taken in Maine hospitals.

The results of this analysis will be distributed to all Maine hospitals during the third and fourth quarters of 1985.

Educational sessions will be developed and presented during the first quarter of 1986, which focus on the identification of patients at risk for PE/DVT, the necessity of documenting such cases, and appropriate prophylaxis.

Health Care Review Inc. will initiate a follow-up study during the second quarter of 1986 to assess the effect of the intervention. Cases will be selected from UNIbill data and review will be performed to determine whether appropriate prophylaxis is being administered.

MILESTONE CHART

QUALITY OBJECTIVE III
Mortality Associated with Pulmonary Embolism

TASK	PERSONNEL RESPONSIBLE	DATE INITIATED	DATE COMPLETED	ESTIMATED IMPACT
Criteria and data collection	Quality Review Committee Maine	1st Q 1985	1st. Q 1985	
Scheme developed by Maine physicians				
Sample Selection for chart review	Data staff	1st. Q 1985	ongoing	
Onsite record review Initial Audit	Quality Review corrdinators	1st. Q 1985	3rd. Q 1985	
Data Analysis	Quality Review data staff	3rd. Q 1985	4th. Q 1985	
Distribution of findings to hospitals	Quality Review Committee and staff	4th. Q 1985	4th. Q 1985	
Educational Intervention	Quality Review Committee and staff	4th Q 1985	1st. Q 1986	25 cases
Follow-up Study	Quality Review staff	2nd. Q 1985	2nd. Q 1986	25 cases
Distribution of study findings	Quality Review Committee and staff	3rd. Q 1986	3rd. Q 1986	64 cases
Corrective Action problem for hospital and physician	Quality Review Committee and Medical Director	3rd. Q 1986	4th. Q 1986	

MAINE QUALITY OBJECTIVE IV

Reduce Unnecessary Surgery or Other Invasive Procedures

III. Description of Review Methodology and Personnel Involved

A. Criteria:

Maine physicians in various specialties have developed criteria for the indications for surgery for the following procedures: TURP, total hip and knee replacement, and coronary artery bypass graft.

The criteria are attached.

B. Timing of Review and Personnel Conducting Review

Utilizing PATbill and UNIbill data, generated weekly by Maine Blue Cross, Health Care Review Inc. will sample Medicare discharges who have undergone the following surgical procedures: total hip and knee replacement, transurethral resection prostate, and coronary artery bypsss graft. Onsite record review will be initiated June 1, 1985 and performed by quality review coordinators in Maine. Data related to the indications for surgery will be collected. See attached data collection forms.

Physician developed criteria will then be applied to evaluate the necessity of surgery. Physicians will review those cases where appropriate indications for surgery are lacking.

The data will be analyzed during 4thQ 1985 to assess rates of unnecessary surgery by hospital and by surgeon. The results of this analysis and the criteria used in the study will be disseminated to Maine hospitals and surgeons during the fourth quarter of 1985.

Health Care Review Inc. will provide the hospitals and surgeons with education as to appropriate indications for surgery during the first and second quarters of 1986. The surgeons will also be offered an opportunity to discuss their cases with physician reviewers--an effective educational step in peer review.

If review results indicate extreme levels of unnecessary surgery, the Quality Review Committee may chose to implement a preadmission review program for the problem procedures.

Throughout the study, the Health Care Review Inc. data department and quality review department will continue to monitor admission rates for surgical procedures to detect aberrant patterns. Data will be analyzed to measure variance in admission rates for surgical procedures. Rates will be adjusted by age, sex, and casemix so that comparisons are based on clinically similar patients at risk for surgery. Based on the results of this analysis, the Quality Review Committee may expand the study to include other procedures which may represent "unnecessary surgery".

A follow-up study will be implemented in the second quarter of 1986 to measure the effect of the education. Physicians found to be non-compliant with Health Care Review Inc. recommendations will be subject to sanction proceeding.

November 1984 March 1985. On-site record review was performed by Health Care Review Inc. quality review coordinators and data was collected as to indications for surgery. The data was analyzed to evaluate the extent of unnecessary surgery utilizing physician developed criteria (attached).

The results of the study are displayed below.

Surgical Procedure	Cases Reviewed	Cases where Surgery not Indicated	%
TURP	135	53	39
Hysterectomy	32	3	9.4
Total hip and total knee replacement	70	21	30
Coronary Artery Bypass graft	25	4	16
	262	81	

Based on the results of this preliminary study indicating that unnecessary surgery is being performed in Maine hospitals, Health Care Review Inc. will establish an objective to reduce admission rates for certain surgical procedures. The study will not include review of hysterectomies due to the low frequency of this procedure among women sixty-five years of age and older and the low rate of problem cases found in the pilot study. Of 32 cases reviewed, only 3 cases (8%) did not meet criteria for appropriate indications for surgery.

Health Care Review Inc. is currently performing data analysis of rates of other surgical procedures to detect variations and potential problems. If the analysis suggests aberrant admission rates, the physicians of the Maine Quality Review Committee may recommend inclusion of the procedures in the study.

II. A. Baseline Measurement

Procedure	# Cases Nov '84-Mar '85	Projected Cases Contract Interval
Total Hip & Knee Replacement	228	1,088
Transurethral Resection Prostate	400	1,920
Coronary Artery Bypass Graft	96	461

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[1] Based on November 1984-March 1985 data

II. A. Baseline

Total Hip Replacement

Hospital Number	# of Cases Nov 84 - Mar 85	# of Cases Projected for 1985	Admission Rate Projected 1985 per 1000 Medicare Enrollees
01	13	31.2	.21
08	2	4.8	.03
09	28	67.2	.45
12	10	24	.16
15	10	24	.16
16	3	7.2	.05
17	3	7.2	.05
18	5	12.	.08
19	3	7.2	.05
24	11	26.4	.18
32	6	14.4	.96
33	19	45.6	.31
39	8	19.2	.12
40	4	9.6	.06
44	2	4.8	.03
50	1	2.4	.02
63	9	21.6	.14
66	9	21.6	.14
Total	146	350 ave. 19.6	ave .13

These rates will be adjusted by age, sex, and diagnosis so comparisons will be made among similar patients at risk for the surgery.

II. A. Baseline
Total Knee Replacement

Hospital Number	# of Cases Nov 84-Mar 85	# of Cases Projected 85	Admission Rate Projected 1985/1000 Medicare Enrol.
001	5	12	.05
009	12	28.8	.19
012	3	7.2	.05
015	2	4.8	.03
016	3	7.2	.05
017	3	7.2	.05
018	2	4.8	.03
024	5	12	.08
032	2	4.8	.03
033	13	31.2	.21
034	2	4.8	.03
037	3	7.2	.05
039	8	19.2	.13
040	3	7.2	.05
041	3	7.2	.05
044	3	7.2	.05
050	5	12	.08
063	6	14.4	.10
066	7	16.8	.11
Total	82	216 average 11.4	average .1per1000

These rates will be adjusted by age, sex and diagnosis, so comparisons will be made among similar patients at risk for the surgery.

II. A. Baseline

TURP

Hospital Number	# of Cases Nov 84-Mar.85	# of Cases Projected '85	Admission Rate Projected 1985/ per 1000 Medicare Enrollees
01	26	62.4	.42
02	5	12.0	.08
03	2	4.8	.03
08	33	79.2	.53
09	34	81.6	.55
12	13	31.2	.21
13	11	26.4	.02
15	23	55.2	.37
16	11	26.4	.02
17	23	55.2	.37
19	22	52.8	.35
20	6	14.4	.10
24	20	48.	.32
25	2	4.8	.03
26	8	19.2	.13
31	9	21.6	.14
32	9	21.6	.14
33	20	48	.32
34	18	43.2	.29
37	9	21.6	.14
38	4	9.6	.06
39	45	108	.72
40	7	16.8	.11

41	3	7.2	.05
43	3	7.2	.05
44	4	9.6	.06
50	4	9.6	.06
51	3	7.2	.05
63	23	55.2	.37
Total	400	934	
		Ave. 32.2	Ave. .22

These rates will be adjusted by age, sex, and diagnosis so comparisons will be made among similar patients at risk for the surgery.

B. Desired Outcome

Previous studies in Maine have shown that the admission rates for several surgical procedures vary extensively among hospital market areas. While these studies recognize differences in physician practice styles as a major contributing factor to variation in rates, they have not assessed the level of unnecessary or inappropriate surgery.

Health Care Review Inc. will reduce the admissions rates for the following procedures: TURP, hysterectomy, total hip replacement, total knee replacement, and coronary artery bypass graft. The targeted admissions rate for each Maine hospital performing one of the procedures will be the statewide norm.

The admission rates for each surgical procedure, both statewide and hospital specific will be adjusted for age, sex, and diagnoses. By adjusting the rates, accurate comparisons of admissions can be made for clinically similar patients at risk for the various surgical procedures.

Also, hospitals will not only be compared to statewide norms, but to norms for categories of hospitals grouped by size and teaching status.

II. B. Desired Outcome

Total Knee Replacement (TKR)

Hospital Number	Projected Cases Nov 1984-Nov 1986	Targeted Reduction	Desired Outcome
001	24	0	24
009	57.6	30.6	27
012	14.4	0	14.4
016	14.4	0	14.4
017	14.4	0	14.4
024	24	0	24.0
033	62.4	35.4	27.
037	14.4	0	14.4
039	38.4	11.4	27
040	14.4	0	14.4
041	14.4	0	14.4
044	14.4	0	14.4
058	24	0	24.
063	28.8	1.8	27.
066	33.6	6.6	27.
	394	86	308

Health Care Review Inc. projects that approximately 394 Medicare admissions will occur during the contract interval for total knee replacements. Health Care Review Inc. will reduce the admissions by 86 cases resulting in 308 admissions.

This impact will occur if admission rates for hospitals exceeding the statewide average are reduced to the statewide norm.

II. B. Desired Outcome

Total Hip Replacement

Hospital Number	Projected Cases Nov 1984-Nov 1986	Targeted Reduction	Desired Outcome
01	62.4	22.4	40.0
08	9.6	--	9.6
09	134.4	94.4	40.0
12	48	8.0	44.0
19	7.2	--	7.2
15	48	8.0	44.0
16	14.4	--	14.4
24	52.8	12.8	40.0
17	14.4	--	14.4
33	91.2	51.2	40.0
18	24.0	--	24.0
63	43.2	3.2	40
32	28.8	--	28.8
66	43.2	3.2	40
39	38.4	--	38.4
40	19.2	--	19.2
50	4.8	--	4.8
44	9.6	--	9.6
	694	203	491

Health Care Review Inc. projects that approximately 684 Medicare admissions will occur during the contract interval for total hip replacements. HCR Inc. will reduce the admissions by 203 cases resulting in 481 cases.

This impact can be expected if admission rates for hospitals exceeding the statewide average are reduced to the statewide norm.

II. B. Desired Outcome

Transurethral Resection of Prostate

Hospital Number	Projected Cases Nov. 84-Nov. 86	Targeted Production # of Cases	Desired Outcome # of Cases
01	124.8	58.8	66
02	24	0	24
03	9.6	0	9.6
08	158.4	92.4	66
09	163.2	97.2	66
12	62.4	0	62.4
13	52.8	0	52.8
15	110.4	44.4	66
16	52.8	0	26.4
17	110.4	44.4	66
19	105.6	39.6	66
20	28.8	0	14.4
24	96	30	66
25	9.6	0	9.6
26	38.4	0	38.4
31	43.2	0	43.2
32	43.2	0	43.2
33	96.	30	66
34	86.4	20.4	66
37	43.2	0	43.2
38	19.2	0	19.2
39	216	150	66
40	33.6	0	33.6
41	14.4	0	14.4

43	14.4	0	14.4
44	19.2	0	19.2
50	19.2	0	19.3
51	14.4	0	14.4
63	110.4	39.6	66
	1920	647	1228

Health Care Review Inc. projects that approximately 1874 Medicare admissions will occur in the contract interval for TURP's. Health Care Review Inc. will reduce the admissions to 1228 cases, which represents a reduction of 647 admissions. This impact will occur if admission rates for hospitals exceeding the statewide average are reduced to the "expected" statewide norm.

Coronary Artery Bypass Graft

PATbill data for time period of November 1984 - March 1985--revealed that 96 coronary artery bypass surgeries were performed in one hospital in the state of Maine.

To evaluate the extent of unnecessary surgery, or surgery that is not medically indicated, Health Care Review Inc. included the procedure in its preliminary study. 16% of 25 cases reviewed were found to be unnecessary.

Health Care Review Inc. will reduce the frequency of unnecessary coronary artery bypass grafts to 10% during the contract interval.

Projected # of Cases Nov 84-Nov 86	Expected # of Unnecessary Surgery	Targeted Reduction in Unneces. Surgery	Desired Outcome
461 cases	74 cases	46 cases	415 cases

MILESTONE CHART

QUALITY OBJECTIVE IV

Reduce Unnecessary Surgery or Other Invasive Procedures

TASK	PERSONNEL RESPONSIBLE	DATE INITIATED	DATE COMPLETED	ESTIMATED IMPACT
Criteria and data collection scheme	Maine physicians and Quality Review staff	Jan. 1985	May 1985	
Review Sample Selected	Data staff	May 1985	ongoing	
Onsite Record review	Quality Review coordinators	June 1985	Nov. 1985	
Data Analysis	Data staff Quality Review staff Quality Review Committee	4th Q 1985	4th Q 1985	
Distribution of criteria, findings, and recommendations to hospitals	Quality Review Committee and staff	1st Q 1986	1st Q 1986	10 Bypass 100 TURP 25 Hip 20 Knee
Educational Sessions	Maine Physicians consultants and Quality Review Committee	2nd Q 1986	2nd Q 1986	18 Bypass 182 TURP 80 Hip 26 Knee
Follow-up study	Quality Re- staff and committee	3rd Q 1986	3rd Q 1986	1 Bypass 365 TURP 108 Hip 40 Knee

MAINE QUALITY OBJECTIVE V REVISION

I. Reduce Urinary Tract Infection in Patients undergoing Total Hip Replacement.

A. Problem Description

Review of PATbill for the months November 1984 through March 1985 revealed 150 total hip replacements. 5% (8 cases) of these patients had a documented diagnosis of a urinary tract infection.

B. Identification/Verification/Validation and Physician Involvement

The urinary tract is the most common site of nosocomial infection reported by acute care hospitals, affecting an estimated 600,000 patients per year.[1]

Most of these infections - 66% of 86% - follow instrumentation of the urinary tract, mainly urinary catheterization. Further, the risk of developing catheter associated UTI is increased in patients with advanced age, debilitation and postpartum state.[1]

To study the association of urinary tract infection in patients with a Foley Catheter, Health Care Review Inc. Quality Review Committee Physicians focused on operative procedures routinely requiring post-operative catherization, thereby, increasing the risk of developing a UTI.

Analysis of data for the time period Nov. 1984 - March 1985 indicated 150 patients underwent a total hip replacement (THR) and 5% acquired a UTI.

In that insertion of indwelling catheter is an ICD 9-CM class 3 procedure, negating consistent reporting of such on the discharge data sheets, the exact UTI/Foley ratio is, at present, unknown. As stated previously, however, the most common cause of post-operative UTI is catheterization.[2]

The Quality Review Committee physicians and consulting urologist concur that there is a direct correlation between the duration of indwelling catheterization and the risk of developing a urinary tract infection. The physicians, therefore, believe that the aged Medicare population along with the debilitating nature of total hip replacement, target these patients as requiring meticulous post-operative catheter care to reduce their rate of UTI.

To assess the use of Foley catheters in total hip replacement surgery, Health Care Review Inc. conducted a validation study. Patients undergoing a total hip replacement were

MAINE QUALITY OBJECTIVE V

Reduce Urinary Tract Infection in Patients Undergoing Total Hip Replacement

III. A. Description of Review Methodology and Personnel Involved

I. Criteria:

Maine physicians have developed criteria relevant to the use of foley catheters in total hip replacement patients.(attached)

Health Care Review Inc. will identify all Medicare discharges undergoing a total hip replacement from 1985 PATbill/UNIbill data provided by Maine Blue Cross. This sample selection will commence during the first quarter of 1985 and continue through the duration of the study as FI data is received by Health Care Review Inc.

Quality Review of these cases will be initiated during the second quarter of 1985, and data will be collected relative to the insertion of the foley catheter and UTI. Criteria developed by Maine physicians will be applied to the data to determine if foley catheter use was appropriate. Questionable cases will be referred to a physician for review.

Data analysis will be performed during the third quarter of 1985 to assess the use of foley catheters in Maine hospitals and subsequent UTI's.

As data analysis is completed at each hospital, individual hospital summaries with recommendations will be provided to hospitals to promote immediate progress toward reduction in the UTI rate. The information will be provided to individual orthopedic surgeons.

Educational material or programs will be developed and presented fourth quarter 1985 and first quarter 1986, by Health Care Review Inc. These sessions will address important infection control measures and appropriate foley catheter use. This includes ways to limit the use of urinary catheterization as well as instruction in methods necessary to reduce infection in patients where the catheter is clearly indicated.

2. Monitoring of Objective Methodology

To assess the affect of the education intervention and to measure the compliance of Maine physicians with recommended criteria and guidelines, a follow-up study will be initiated during the third quarter of 1986. Cases to be reviewed will be retrieved from current UNIbill data.

Record review utilizing the same physician criteria will be preformed by the quality review staff. The study will be completed by third quarter 1986. Hospitals and surgeons will be informed of all findings.

UTI STUDY

Acceptable duration of catheterization (foley) total hip
for surgical procedures.
No more than 48 hours post-op

MILESTONE CHART

QUALITY OBJECTIVE V

Reduce Urinary Tract Infections in Patients Undergoing Total Hip Replacement

TASK	PERSONNEL RESPONSIBLE	QTR INITIATED	QTR COMPLETED	EXPECTED PROGRESS IN ACHIEVING 40% REDUCTION
Revision of criteria and review of Maine physicians	Quality Review Committee phys. Quality Review staff	1st. Q 1985	1st. Q 1985	
Distribution of criteria and expectations to hospital physician committees	Quality Review Committee phys. Quality Review staff	1st. Q 1985	1st. Q 1985	
Selection of patients for review	Quality Review staff	2nd. Q 1985	2nd. Q 1985	(2nd. Q 1985) 5%
On-site record revies	Quality Review Committee phys. Quality Review staff	2nd. Q 1985	4th. Q 1985	(3rd. Q 1985) 10%
Tabulation/ analysis of data	Quality Review Committee phys. Quality Review staff	3rd. Q 1985	1st. Q 1986	(4th, Q 1985) 15%
Distribution hospital summaries	Quality Review Committee phys. Quality Review staff	3rd. Q 1985	1st, Q 1986	(1st. Q 1986) 20%
Educational sessions/ materials	Health Care Review Inc. phys. Health Care Review staff	4th. Q 1985	1st. Q 1986	(2nd. Q 1986) 25% (3rd. Q 1986) 30% (4th. Q 1986) 35%
Follow-up to determine compliance and URI reduction	Quality Review Committee phys. Quality Review staff	3rd. Q 1986	1st. Q 1986	(1st. Q 1987) 40%

UTI REFERENCE

1. Center for Disease Control: Guidelines for Prevention of Catheter Associated Urinary Tract Infections and Guidelines Ranking Scheme, Infection Control 1981; Vol. 2, No. 2

2. Luckman and Sorensen: Medical-Surgical Nursing - A Psychophysiologic Approach; W.B. Saunders Co.; 1980; Pg. 420

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[illegible]

might [illegible]

[illegible]

[illegible]

Reporting Date: 07 / 17 / 85

NDHCRI INCIDENCE REPORT TO REGIONAL OFFICE

Patient Name:____________________ HIC NO.:___________ Age: 82

Admit Date: 3 / 20 / 85 Hosp. Name____________ MPR No.35-_____

Physician Name:__________________ M.D. License No.:__________

Reviewer Numbers: R.S. [redacted] P.A. [redacted] Reviewed: 7 / 5 / 85

Incidence Type:

X A. Readmission Subsequent to a Pre-mature Discharge
___B. Transfer Of a Questionable Nature
___C. Hospital Initiated Denial Not Reported on Monthly List
___D. Inappropriate Hosp. Init. Den. Issued Prior to DRG ALOS

(Narrative description of the problem or discrepancy using as accurate direct language as possible. Use physicians orders and physician advisor notes for quotations where possible.)

This patient was first admitted on 3/20/85 with Septicemia and discharged 3/26/85. On 3/26/85 the patient was transferred to ICF. The PA comments: "I feel this was a premature discharge. Septicemia with temperature elevated on day of discharge". This patient's second admission occurred on 3/27/85 and the patient expired on 3/28/85. The second admission was also for Septicemia.

Distribution - Type	A B C D
NDHCRI	A B C D
Regional Office	A B C D
Hospital	A B C D
Attending Physician	A B C D
Fiscal Intermediary	D
Patient	D

MISSOURI
PATIENT CARE REVIEW
FOUNDATION

1026 C Northeast Drive • Jefferson City, Missouri 65101 • (314) 634-4441

Mohammad N. Akhter, M.D.
[illegible]

Thomas E. Mangus
[illegible]

July 24, 1985

Mr. Greg Lear, Chief
Medical Review Branch
Health Standards and Quality Bureau
601 East 12th Street
Kansas City, Missouri 64106

Re: Contract No. 500-84-0526-85 MO 007
Premature Discharges and Inappropriate Admission

Dear Greg:

I have enclosed for your review the record of a patient who was admitted to the Kansas University Medical Center in Kansas City, Kansas and subsequently readmitted to - St. John's Regional Medical Center in Joplin. We have had several medical specialist in cardiology review this case all of which agree as a premature discharge and questionable quality of care, including a re-review by the Kansas Foundation for Medical Care which also agrees to premature discharge and the possiblity of inadequate care given to the patient at the Kansas University Medical Center. My question is what action, if any, can the PRO take regarding this case or similar cases?

The second enclosure is a copy of a medical record in which the Medicare patient was admitted for an invasive procedure for cardiac catherization, discharged two days later and readmitted five days later to perform bypass surgery. What is HCFA's policy regarding the handling of these types of cases since two DRGs were generated? Should we perform a technical denial on the first or second admission?

I would appreciate your response to both types of cases referred to above at your earliest convenience.

Sincerely,

Thomas E. Mangus
Director of Operations

TEM:bjs
Enclosures - 2 [Enclosures not provided by HCFA]
cc: Mohammad N. Akhter, M.D.

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IFMC
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Fed Exp. 7/31

06
IA7
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July 30, 1985

[illegible] Jul 31

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Ben Gruber, Project Officer
Division of Health Standards & Quality
Region VII
Federal Office Building
601 East 12th Street
Kansas City, Missouri 64106

Contract No.: 500-84-0513
Correspondence No.: 85-51
Topic: Information Requested on PRO Quality of Care Assessment
and Corrective Action

Dear Ben:

We have several mechanisms by which we monitor quality of care and identify areas of concern.

All reviews conducted by IFMC include a quality component. Our worksheets specifically request a response concerning the quality of care. Cases may be identified for further review by our Quality Assessment Committee. Cases may be referred by IFMC review staff or by physician's reviewing for us. Following committee review, an educational letter is directed to the physician responsible for the questionable care.

All readmissions within seven calendar days are reviewed for the possibility of the occurrence of a premature discharge. If reviewing physician determines that the second hospitalization was the result of premature discharge during the first hospitalization, or that the patient could have been cared for during one hospitalization, an educational letter is sent. This letter includes the rationale of the reviewing physician. Thus far, 413 premature discharges have been identified.

A second premature discharge will result in a case presentation to the IFMC Comprehensive Review Committee with a recommendation for predischarge screening. The predischarge review requirement is in effect for three months. Discharge cannot be prevented and no denials are issued. The review is educational. Thus far, two physicians have been placed on predischarge review.

IFMC staff are also acutely aware of the concerns of Medicare beneficiaries and their families. We follow up on phone calls and letters concerning difficulties experienced by Medicare beneficiaries. Our first step is to determine IFMC involvement in any reviews or denials. Whether or not we were involved in a case, we make every effort to clarify or resolve the problem.

We have recently assessed several situations where family members felt that a Medicare beneficiary was denied access to acute hospital care or was discharged too soon from an acute hospital. In these cases, we assisted family members in attempting to address the issue, despite the fact that IFMC was never contacted to review the cases. (The providers and practitioners told patients that Medicare would not pay even though no review had occurred by the PRO without obtaining review from the PRO.)

As always, the quality of care provided in Iowa is of genuine concern to us.

Sincerely,

Fred Ferree/lkj

Fred Ferree
Executive Vice President

FF:lkj

BB

THE KANSAS FOUNDATION FOR MEDICAL CARE INC.
2953 S.W. Wanamaker Drive / Topeka, Kansas 66614
Telephone: (913) 273-2552

Fed. Express 7/31/85

③

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July 31, 1985

Ms. Brenda Burton
PRO Project Officer
Medical Review Branch
Health Standards and Quality Bureau
Health Care Financing Administration
Department of HHS, Region VII
Federal Office Building, Room 284
601 East 12th Street
Kansas City, MO 64106

RE: 1. Quality Assurance Committee Concerns and Recommendations for Other Areas of Quality Review

2. Reorganization Structure for Monitoring Quality Problems

HCFA 500-84-0506
#0107

Dear Brenda:

SECTION I - Areas of Quality Review for PROs Area Ambulatory Surgery Review

With the shift of inpatient to an outpatient setting occurring more and more throughout the nation, I think it is essential that the PROs focus on selected procedures thereby making a "preprocedure review". It is recommended that high volume procedures be looked at for the indications for the surgical procedure. This would include but not be limited to cataracts, G.I. endoscopies, bronchoscopies, and cystoscopies.

Cataract surgery is one primary example of the need for such review. There is no question in my mind but what the total number of cataracts done has increased simply because no quality assurance studies in monitoring can be done on an outpatient basis at the present time. Criteria could be set up for each of these procedures and preadmission certification be done looking entirely at the indications for the surgical procedure.

Mandatory retrospective sampling, probably 10-20% of these procedures to look for 1) complications, and 2) subsequent admission to the hospital. The information necessary for this would include the following:

1. A list of the acceptable procedures and their indications
2. Also request a copy of the preprocedure certification or match them up
3. Request a copy of the operative report
4. Monitor all hospital admissions occurring within 24 hours of the procedure
5. Possibly monitor the anesthesia time in excess of 1-2 hours
6. A pathology report where appropriate (this may produce some difficulties because physicians have a difference of opinion as to where and when a pathology report is needed). This would be spelled out in the preadmission certification criteria as to whether a pathology report were mandatory or not.
7. Possibly would want to review patient instructions post-operatively.

I think that this would allow us to develop a profile of every physician or surgeon doing outpatient work very quickly, probably within 3-6 months certainly and possibly have the fiscal intermediary even flag certain things if they occur such as the complications or admissions.

In order to continue ambulatory surgery review, I think it is important that we develop a "new" UB-82 form for outpatient or ambulatory review. The Quality Assurance Committee of AMPRA has developed this question and recommended that the Data Committee study this and come up with an appropriate form. The above recommendations will be made to the Data Committee in the hopes that they can come up with a uniform form with the elements for ambulatory surgery review. This would include such things as lab codes, ancillary procedures and whatever other elements might be needed.

SECTION II - Premature Discharge.

These probably should be identified as done previously with the following comments.

1. Utilize discharge screens on charts reviewed.
2. Do a focussed concurrent review if any attending physician has three cases or more during any given time period. It is important to remember that the hospital administration may be putting undue pressure on the physicians for these premature discharges and it is important that the hospital be held to its share of responsibility.
3. I think it is important to inform the physician if a premature discharge is identified.
4. Will probably extend the review for readmissions within seven days to at least 10-14 days.
5. Institute a more or less national uniform "furlough" situation for patients where only one DRG is paid when the patient may need to go home between the initial preoperative evaluation and subsequent surgery.

Other items to go along with this would be to try to monitor patient outcomes. Certainly the intensity of service provided during the hospitalization and perhaps, utilizing the patient's social security number, be able to track down mortalities that occur within a certain time after discharge from the hospital.

Another item would be possibly to consider tracking every hospital issued denial on a sampling basis for patient outcome.

Another item might be for preadmission certification on any level of nursing home or transfer from a hospital to a nursing home that might be indicative of a premature discharge. This might have to include eventually the home health services and hospices. This preadmission certification probably should be for any extended level or sustaining level of care such as a skilled nursing facility, intermediate bed, whatever as long as that patient has been recently discharged or transferred from the hospital.

The important thing is to keep in mind, "is it safe" to transfer so many patients of the Medicare age group population to the outpatient setting. Along with this would be beneficiary education and this might be done by a selected sampling of each institution on a Regional basis once a year or other methods that might be developed.

SECTION III: Additional Quality

It is recommended that the PROs have some latitude for the development of their quality objectives. Probably should be allowed to develop our own quality studies as long as we have data to support those studies. Perhaps 20-50% of the quality objectives could be on a local basis rather than a national basis but it is difficult to know.

SECTION IV: The information on the Pat Bill, that is the cost data, may identify quality problems. That is, outliers of either cost or days may at least indicate the possibility of a quality problem during their treatment.

RE: Reorganization of the Quality Assurance Committee

In an effort to make the Quality Assurance Committee's actions more meaningful and responsive to the problem, a system of ranking the quality problems has been developed. This would basically be in the form of a chart or identified columns that could be maintained on the computer for on-going review. These would include across the top the physicians I.D. number, the hospital, the chart number and then the ranking system would include five categories. The first one would be documentation. That is, if the problem was not necessarily the medical care delivered but rather the documentation by the attending physician, this would be identified, and if a pattern developed, action taken to educate the physician. The second, third, fourth and fifth columns would include level I, II, III, and IV. Level I would be nonstandard or unusual treatment or practice that potentially endangers the patient and no detrimental effect was realized. Level II would be nonstandard or unusual treatment or practice that clearly endangers the patient resulting in short term detrimental effect. Level III would be nonstandard or unusual treatment or practice that results in significant morbidity and number IV would be the gross and flagrant quality violations usually but not necessarily ending in mortality. These come up within rank the quality problem, I, II, III, IV, that is, potential, short term, morbidity, and mortality. The last column would be generic screening numbers. Under this column would be the quality generic screening criteria of which, we have nineteen listed. The number of the quality issue that corresponds to that identified would simply be inserted in this column. There may be one or more numbers appropriate.

With this ongoing identification of quality problems, this information could be brought up on the computer, on demand and see if there is any pattern developing that needs attention for the lower ranked numbers, that is, for the documentation and Level I.

It is recommended that documentation problems and Level I be identified by the Physician Reviewer and handled on-site when desirable. On a separate sheet have the Physician Reviewer state the quality problem, and send a copy to the attending with a copy to the Quality Assurance Committee in the office to be inserted on the computer. As these are brought up, it becomes quickly apparent if there is a pattern of poor documentation that has developed, that needs further attention.

On Category I, this division would be at the decision of the Physician Reviewer whether he handled it in the field by writing on a separate sheet, again with a copy to the Quality Assurance Committee Supervisor or whether he wanted to refer to the Quality Assurance Committee Executive Board.

Categories II, III and IV would be referred to the office and reviewed by the Medical Director or his associate or a member of the Quality Assurance Committee on-site. The Medical Director or his designee refers it to a specialist for a written consultation, if appropriate and then when it comes back, send it to a Quality Assurance Executive Committee which should be made up of five members of the Quality Assurance Committee who would meet at monthly regular intervals. This would assume that at least three members of this Committee could be present and review these charts of the Level II, III and IV. At that time, they would make the decision
1) whether it would be a hearing, that is call the physician in,
2) whether it would be a formal hearing with potential sanctions, or
3) whether they would simply recommend corrective action to the attending and the hospital.

A regular follow up at intervals would be required to assure that if the corrective action had been designated to the hospital Quality Assurance Committee, that indeed, action was taken and satisfactory correction obtained.

Sincerely,

G. Rex Stone, M.D.
Medical Director

tp

0366/2-6T

XC: Trudi Galblum

Rec'd Fed Express 7/31/85

13

MISSOURI
PATIENT CARE REVIEW
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Mohammad N. Akhter, M.D.
Executive Vice President
and Medical Director

Thomas E. Mangus
Director of Operations

July 31, 1985

Mr. Greg Lear, Chief
Medical Review Branch
DHHS/HCFA/HSQB
601 East 12th Street
Kansas City, MO 64106

#500-84-0526-89
MO 007

Re: Quality Problems Identified by the Missouri Patient Care Review Foundation

Dear Mr. Lear:

This is in reference to a telephone call from Brenda Burton asking for some of the quality problems identified by the PRO during its review process. I will list these problems in order of priorities:

(1) Inappropriate utilization of antibiotics -- This is the number one problem that we have identified where either inappropriate antibiotics were prescribed or antibiotics were prescribed without getting culture and sensitivity; or in cases where no antibiotics were necessary, antibiotics were given to the patients. There were several instances where a combination of antibiotics was used, without any regard to their toxicity to the liver or the kidney. In each one of these cases of inappropriate utilization of antibiotics, the physicians were notified and were asked to look into the area of our concern and to get back to us. Physicians who repeatedly continue to inappropriately prescribe antibiotics, we had asked for personal meetings with us. So far, the majority of physicians, although reluctantly, have complied with and considerable improvement has been made in the utilization of antibiotics, including development of criteria and standards for the use of antibiotics in the hospital.

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(2) Inappropriate utilization of anticoagulants -- This is another area where we have found cases where anticoagulants were prescribed either without a definite indication for such drugs or without doing adequate pre- and post-testing of the blood and bleeding tests. Patients were kept on anti-coagulants for long periods of time; and in one instance, a patient was operated on while still on anticoagulants, without doing any bleeding and clotting time leading to severe bleeding and multiple transfusions to save the life of that individual. In each one of these instances, again, a letter was sent to the physicians pointing out our concerns and asking for his response.

(3) Poor quality of care due to misinterpretation -- In several cases, particularly cardiology cases, the electrocardiograms were not read by a cardiologist; several mistakes were made in the interpretation of the electrocardiograms, and inappropriate medications were at times prescribed for cardiac conditions. In several instances, no medications were given when they should have been provided for based on the electro-cardiogram findings. In each of these instances, discrepancies were brought to the attention of the physician through a letter, and they were asked to respond to our concerns.

(4) Inappropriate use of medications -- There were several cases where inappropriate medications were used for the treatment of patients. These medications were either not indicated at all for the specific condition, or the medications that were prescribed were not approved, at least in one case, by the Food and Drug Administration for use. Again, in each one of those instances, the physicians were contacted, informing them of the problem and asking for their response.

(5) Lack of treatment -- In several instances, no treatment was provided to the patient. In one case, a secondary diagnosis of pneumococcal pneumonia was made. However, no culture, no sensitivity, and no treatment was provided.

(6) Inappropriate management of psychiatric conditions -- No injury protection measures were ordered after positive psychiatric consultation and prior injury record recorded in nurses notes. As a result, patient received severe injuries while in the hospital.

(7) Treatment provided when patient did not need any treatment -- Gentamycin and Ampicillin prescribed with a temperature of 98.6 and white count of 6,800 and a negative chest x-ray.

(8) Too many procedures at the same time -- Cataract surgery was done on a patient on both eyes in the same setting, which is not an established practice recommended by the Ophthalmology Board.

(9) Poor quality of anesthesia -- Loss of vitrous fluid from the eye during cataract procedure because patient woke up during anesthesia.

(10) Poor quality of procedure -- Placement of nasalgastric tube into the lungs, and feeding was provided, resulting in pneumonia.

(11) Unnecessary surgery -- Inappropriate surgical procedures performed, particularly TUR and hysterectomy, when one was not indicated.

(12) Premature discharge -- There have been several readmissions due to poor quality care provided during the first admission. These cases range from unresolved pneumonia which was sent home to a poorly healed wound where the patient was sent home and was brought back again within a short period of time with complications of illness. In one instance, for example, the patient was still having a bloody discharge from the wound. The patient was sent home and had to be brought in the next day, and surgical repair had to be done.

(13) Poor post-operative care -- Surgeon left after the surgery with no post-operative care. Patient developed shock and had to be transferred to another hospital.

In most of the quality cases, we sent letters to the physicians; and in some instances, these letters were followed up by personal meetings to resolve the issue. In several instances, meetings were conducted with the medical staff of the hospital to resolve the problem.

Sincerely,

Mohammad N. Akhter, M.D., M.P.H.
Executive Vice President and
Medical Director

MNA/dh

NE'1/BG

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NEBRASKA FOUNDATION FOR MEDICAL CARE, INC.
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Fed. Exp. 7/3/85

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Medical Director
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Omaha

July 31, 1985

Mr. Ben Gruber, Project Officer
Medical Review Branch, Division of Health Standards
and Quality
Department of Health & Human Services
Health Care Financing Administration, Region VII
Federal Office Building
601 East 12th Street
Kansas City, MO 64106

RE: 500-84-0529, #44

Dear Ben,

All Medicare medical records reviewed by NFMC will be screened for quality after patient discharge. Cases not conforming to criteria will be referred to an NFMC physician reviewer. The physician reviewer will review the case and determine if the variation is justified. If the physician reviewer cannot justify the variation, the case will be referred to NFMC's Quality Assurance Committee, a letter will be sent to the attending physician notifying him or her of a potential problem and ask for a response within 30 days. The chief of the medical staff and hospital administrator will receive copies of this correspondence. If the Quality Assurance Committee can justify the variation after reviewing the response, a notification letter of the justification will be sent to the attending physician, chief of medical staff, and hospital administrator. No further action will be taken. If the Quality Assurance Committee cannot justify the variation, intervention strategies will be implemented. In cases where no response is received from the physician, the hospital will be asked to initiate intervention strategy.

The following cases have been referred to NFMC's Quality Assurance Committee and are pending response from the physician:

Case #1: Physician removed the hip screw and obtained culture and sensitivity and packed open wound first day after admission. Two days later the patient was taken to surgery for a head and neck total hip prosthesis. During hospitalization the patient received

L

25 units of blood and had a secondary diagnosis of acute post hemorrhage anemia. Patient expired on 48th day of hospital admission. This case was referred to the QA Committee for review of the necessity of the hip prosthesis surgery.

Case #2: Total knee replacement performed. No documented rationale in the record or no preoperative evaluation by orthopedic surgeon. This patient had multiple admissions and all records indicate existence of atrial fibrillation, however this diagnosis was never substantiated in any of the records. Also, physician reviewer determined patient had gangrene. This case was referred to NFMC's QA Committee for failure to recognize gangrene of leg and early attempts at intervention, premature discharge, and questionable surgical procedure.

Case #3: Patient admitted for z-plasty type closure of sacral decubitus. A culture done showed Staph Aureus on the preliminary report. The patient was discharged the next day before the final culture was done. There was no documentation in the medical record that the physician was aware of the final report. Four days after dismissal the patient was re-admitted from the nursing home with breakdown of the incision site over the sacrum. This was referred to NFMC's Quality Assurance Committee for failure to treat the Staph infection and premature discharge.

Case #4: Patient admitted with pneumonia. Symptoms were shortness of breath, wheezing, fever, cough, increase in white blood cells. The physician reviewer felt this was a probable pneumonic infiltrate. This case was referred to Quality for poor quality of service, i.e., no ABG's, no culture, no gram stain, no bronchodilator treatment, and no PFT's were obtained during this patient's admission.

Case #5: Patient admitted with acute abdomen and in shock. Upon admission it was noted by the admission staff that the patient had 100 cc's of cherry red blood in the stool. There was no documentation in the medical record that the patient was seen until two days later by the attending physician. During the first two days the physician followed the patient's course by telephone only. Two days after admission the patient was scheduled for an exploratory laparatomy. The preop evaluation stated the patient's progress was extremely poor. The patient went to the operating room and expired the next day. This case was referred to NFMC's Quality Assurance Committee for review of quality of preoperative care.

Case #6: Patient was still receiving insulin on sliding scale with three to 4+ glycosuria and trace of ketones on the day of dismissal. The day after dismissal the patient was readmitted due to diabetic acidosis with a blood sugar of 900. This case was referred to NFMC's Quality Assurance Committee for incomplete management of patient care during the first admission.

Case #7: The admission diagnosis and principal diagnosis of this patient was congestive heart failure with additional diagnoses to include diabetes, complicated, adult. After the review of the record, the NFMC Physician Reviewer determined that the patient's principal diagnosis was controlled diabetes mellitus. On the day that the blood sugar revealed 389 mgms. % the attending physician documented in the progress notes that diabetes was ok. On the day prior to dismissal the patient had 4+ glycosuria. This case was referred to NFMC's Quality Assurance Committee for lack of clinical management of diabetes mellitus, uncontrolled at the time of discharge.

Case #8: Patient's admission and principal diagnosis was left heart failure. The patient had a BUN of 45 and creatine of 2.2, hemoglobin of 11.8, and hematocrit of 32. The patient was also noted to have pulmonary edema. This case is being referred to NFMC's Quality Assurance Committee for lack of treatment/testing as follows: no telemetry, no O_2 on admission, no ABG's, no heparin lot, no IV diuretic, no follow-up on the BUN or creatinine level, no recheck of the hemoglobin or hematocrit. The attending physician also initiated Quinidine anti-arrhythmic medication without any EKG documentation of arrhythmia in the medical record.

Case #9: Patient was admitted complaining of dyspnea upon exertion x 5 weeks. The admission diagnosis was dexocardia, probably congenital with slightly scaphoid sternum. A chest film done the day after admission showed 80 to 90 per cent pneumothorax. A follow-up chest film was not done until 5 days after the first one. Seven days after admission a chest tube was placed. Following insertion of the chest tube the pneumothorax initially decreased to 10 per cent, but as time progressed, the pneumothorax fluctuated between 10 to 20 per cent and the patient developed subcutaneous emphysema and atelectasis. The air leak continued even with adjustment in the chest tube set-up. Ten days after insertion of the chest tube a wedge resection left lung apex and pleural abrasion was performed. This case is being referred to NFMC's Quality Assurance Committee for review of 1) timeliness of insertion of chest tube in apatient with pneumothorax of 80 to 90 per cent and 2) a review of the 10 day time delay prior to wedge resection.

Case #10: Patient admitted with metastatic CA of the lung. Blood pressures throughout the stay were 230/80, 200/60, 230/82, 210/90, and 220/86. There was no mention in the medical record of hypertension nor was a diagnosis of hypertension established, therefore, no treatment rendered during this admission. The patient was discharged and readmitted the next day due to a fall she incurred while at home. She was brought in by ambulance and was determined to have a thoracic compression fracture. This readmission resulted in a 7 day stay.

Although the QA Committee has not convened to review these cases, it is my belief that the Committee will implement QA Intervention Strategies per NFMC Review Plan as follows:

Individual Physician Consultation with
Chief of Medical Staff
NFMC Physician Consultant
NFMC Medical Director
NFMC QA Committee Chairperson or Designee

I trust this information is helpful. If you have any further questions, please do not hesitate to call.

Sincerely yours,

Nancy L. Balmer, RRA

Nancy L. Balmer, RRA
Manager of Review Programs

NLB:cb

cc: Kenneth E. Neff, Executive Director
John D. Coe, M.D., Medical Director

yellow

DEPARTMENT OF HEALTH & HUMAN SERVICES

Health Care Financing
Administration

Region VII
Federal Office Building
601 East 12th Street
Kansas City, Missouri 64106

July 31, 1985

Larry Pitman
Executive Director
Kansas Foundation for Medical Care
2953 SW Wanamaker Drive
Topeka, Kansas 66614

Refer: HCFA 500-84-0506

Dear Mr. Pitman:

The purpose of this letter is to document the results of the Regional Office Monitoring visit on July 24-26, 1985. Below are the status of activities discussed and the agreements/recommendations made. Summary I, attached, is the updated status of activities which deal directly with identified items on the PROMPTS document. Please note the deadlines specified within the review activity discussed below.

Status
Rec. 6/23 ltr

Confidentiality:

We reviewed onsite KFMC's Confidentiality Policy, as well as copies of requests for data involving significant time and/or sensitive information. Gary agreed to establish a single file pertaining to all disclosure activity. We were pleased to learn that actions were being taken to enhance the security of data and medical records in KFMC's new building. However, we strongly recommend that medical records be further protected by locks or bars on windows leading to that area.

completed

Sanctions:

We have reviewed Gary's sanction policy memorandum dated June 18, 1985, in comparison with the April 17, 1985 final rules. There appear to be some disparities; for example, the regulations require that the practitioner or other person be given 20 days to submit additional information or discuss the problem, whereas Gary's memo specifies 30 days. Please make this and any other changes in the policy necessary to bring it into conformance with the regulations. Any future revisions to your review plan should also include an update to your sanction policy. I would like to receive copies of corrected and revised material. I would also like to be kept informed about the two sanctions currently under development.

completed

original [illegible].

Fraud and Abuse:

You indicated that no cases of potential fraud and abuse have been identified to date.

Quality Review:

Discussions with Diana Mallott and Dr. Stone, as well as review of several QA cases referred to the Quality Assurance Committee (QAC), affirmed that KFMC is following its process for assuring quality as defined in the review plan. We noted, however, that there appeared to be little evidence of strong and aggressive action in cases we reviewed or described by Dr. Stone and Diana. This was attributed to (1) lack of patterns of substandard care and (2) education and communication efforts to avert recurrences or problems. While we support the latter, we felt that more could be done to identify patterns of substandard quality.

Dr. Stone described his current effort to coordinate development of a revised quality assurance plan including stratification of the severity of the quality problem according to a generic list of adverse patient occurrences. In addition, the results of this stratification and the outcome of QAC review, would be automated. This would provide KFMC with a management tool for identifying "substantial violations" (i.e., patterns). We encourage KFMC to proceed in this direction.

in process

You will provide us with copies of any documents developed in this area. We would also like a copy of the Physician Reviewer Manual which Diana showed us in draft.

(revision [illegible])

Specialty Hospital Review:

We reviewed examples of files from all types of PPS exempt units and long term psychiatric hospitals, with the exception of swing bed hospitals. Speciality hospital review is occurring in accordance with your review plan (see Data section of this letter regarding swing bed review).

[redacted]

Data:

PROMIT III Implementation - John Edmonds is to forward a letter describing activities around the change from PROMIS I to PROMIS III. This will include installation of selection criteria, updating master files, generating revised reports and the basic difference between the two programs. I would like this report no later than August 31.

Rec'd
8/30/[illegible]

HCFA-516 Revisions - I was given the data to support the first revisions to the HCFA-516s. These reports were generated under PROMIS I. I expect the actual revised HCFA-516s no later than August 2.

Rec'd 8/15

PROMIS III 516s will be forwarded for all contract months no later than August 31. KFMC has decided to define "reviews completed" as those returned and entered into the data system. These latter 516s will reflect the use of this definition.

on schedule
Rec'd 9/3

HCFA-511s - While onsite, I talked with John about errors in the HCFA-511s. He corrected the HCFA-511s for the quarter ending March 1985 for Kansas and Nebraska and gave to me for forwarding to Baltimore. All previous HCFA-511s for Kansas and Nebraska need revision and forwarding to Baltimore.

need date

Adjustment Tapes - John indicated that he would have an adjustment tape ready for forwarding to the FIs by August 1. We discussed the FIs ability to process and I instructed them to forward these when he got them completed. John was concerned about identification of adjustments as a result of PRO review back from the FI. According to Central Office, a new instructions about this was forwarded to the FIs and I promised to forward a copy of KFMC.

completed

Patient Status Code 30 and 40 - As instructed by Central Office, KFMC is to hold these cases until a final bill is forwarded by the FI.

completed

Prepayment Screens by FI - John has had little discussion with the FIs about this activity. I told him I would forward a copy of the package to him so he would know what the FI would need and he will be prepared when necessary.

progressing

[illegible] 8/23

Identification of Cases from Other than PROBILL - The KFMC data system still cannot handle such cases. MIS personnel were to be in Topeka July 29 to initiate this activity. I want a status report of these meetings with a completion date for this activity.

need date

Backlog of Reviews - KFMC has cleared the cases in backlog. This was a major effort and I am pleased with the results. With the contiguation of the aging reports, you should be able to avoid problems in this area in the future.

up to date

PRO/FI MOUs - KFMC has decided to not revised the MOU at this time becuase they felt that the cooperation between the PRO and the FIs is allowing progress in activity areas. John Edmonds agreed to send me a letter about this decision. I would like this letter no later than August 15.

Rec'd 8/22

Physician ID on Swing Bed Cases - There are many cases with incorrect physician IDs. This was due to the fact that the FI was not processing swing bed cases until recently. John felt KFMC could handle getting the IDs corrected. I advised him that if he chose, I would support his sending these cases to FI for development.

continuing

New Error Lists as Result of PROMIS III Implementation - I asked John to send copies so I could see the type of errors being received.)

rec'd
asked to stop on 2nd send

DRGs for Exempt Hospitals/Units - While reviewing the hospital profiles, I found that exempt hospitals and units have a DRG assignment made. I recieved a listing of these cases from John and will forward for review by other Regional Office staff.

completed!

Pending Error Corrections - Discussions are continuing on the corrections of the PRO edits. I am going to notify Abbott Gelerter of Central Office to become directly involved in the technical details of the edits. I will want to be kept informed of KFMC concerns as they relate to HSQB policies.

continuing

Objectives:

KFMC has prepared revisions to each of their Admission Objectives and 4 of their Quality Objectives. We discussed these revisions in some detail. You indicated that you would be forwarding a formal request for modification shortly. Some decisions regarding baseline data and intervention strategies was to be made prior to this formal request. Upon receiving the request, I will review and discuss any concerns with you. I will made my recommendation promptly once agreement has been reached. The Contracts Office should be included in all correspondence in this regard.

need data
Rec'd 9/3/85

Items from Prior Monitoring Visits:

Wesley Case - one case remaining from last monitoring results. The updated results were given me during this visit.

Reconsideration Backlog - there remains a backlog of cases, yet efforts are being made to correct this as soon as possible. Please notify me of the completion of this backlog.

CAF
8/21

KFMC response to medical review performed by Aleta in April - the response to the individual cases is in typing and will be forwarded to the Regional Office.

CA 8/31 Rec'd 9/3/85

Ness City cases review - this review is still being completed by a nurse. When the results have been received, we will forward them to you.

Continuing Rec'd 9/9/85

I want to thank you and your staff for the cooperation you showed Trudi and I during this visit. The KFMC response to problems identified in the past monitoring visits is appreciated and progress is being made on all unresolved issues.

Sincerely yours,

Brenda Burton, Project Officer
Medical Review Branch
Division of Health Standards & Quality

Enclosure - Summary I

KFMC

Monitoring Visit - July 24-26

Summary I

PROMPTS Update

Below are the changes made as a result of our monitoring for those items on the PROMPTS which were "no" or "partially met".

Data 6a "Yes"

Error corrections are forwarded to the FI by hard copy and FI is making corrections and returning to PRO. The number of errors are minimal. However, there is a problem with physician IDs. The Kansas Board of Healing Arts only updates their list every six months. Beacuse of this, the PRO experiences many errors in this field. The PRO is getting the necessary information and correcting the records themselves.

Data 7d "Yes"

The HCFA reporting requirements are met through the PRO data system. Much effort has been expended to correct the deficiencies of the HCFA-516 reporting format and data staff are making necessary changes to reporting on the HCFA-511s.

Medical Review 2 "Yes"

Recent updates to the HCFA reports have brought this item into compliance. Work continues to finalize the HCFA-516 and revise all previous reports. These revisions will more accurately reflect PRO activity.

Specialty Hospitals 3 "Yes"

The PRO is conducting review in accordance with its plan. In the Summary which describes our findings/recommendations in this area, we describe this process. The number of specialty reviews is low in volume.

Reconsiderations 6 b "partially met"

There are still some in backlog, but PRO has placed a priority on elimination. A large portion of backlog is due to hospital tardiness in submitting record. In reconsiderations, the PRO is required to complete the process within 30 days of receipt. There is no allowance for delay due to a hospital not forwarding the medical record. These reviews must be completed within 30 days of request.

Those items from former visit which were "no" or "partially met" and did not change:

Data 6b "No"

The PRO has not received any information from FI as a result of changes based on PRO review decisions.

Data 11a "No"

Same as 6b response

Data 12a(3) "Partially Met"

PRO has the capability of producing patient profiles, but has elected to not produce due to confidentiality problems.

Data 13a. b. c. d. "Partially Met"

PRO has produced profiles but have not forwarded to hospitals yet.

Medical Review 3 "No"

The PRO data system cannot handle any review decisions as identified cases when not part of PROBILL.

Medical Review 10 "No"

Same response as 3 above for DRG 462s.

Medical Review 13. a. b. "No"

No experience in this area to date.

Denials 4. "No"

This area was not covered by the July monitoring visit. The response from April visit was "not always." Letters are sent last day of review month. This item will be covered in subsequent monitoring.

File OMPRO #3

OMPRO

OREGON MEDICAL PROFESSIONAL REVIEW ORGANIZATION

1220 S.W. Morrison, Suite 300
Portland, Oregon 97205
(503) 243-1151

VIA TRANSERV SYSTEMS, INC./COURIER

July 31, 1985

Don Tabor
Contract Specialist
Health Care Financing Administration
East High Rise Building, Room G-10-A
6325 Security Blvd.
Baltimore, Maryland 21207

RE: CONTRACT #500-84-0511

Dear Mr. Tabor:

The following is a summary statement of impact to OMPRO by IM-85-1, IM-85-2 and IM-85-3, as requested by the Region X office.

The documents submitted with Form 60, support Oregon Medical Professional Review Organization's (OMPRO) request for an additional $132,983.00 for the Phase II contract year. While not the only contributing factor, the DRG validation changes are a major cause in requesting an increase in the fixed price of contract number 500-84-0511. The requested modification increases the Phase II total from $1,771,645.00 to $1,904,628.00. The Phase I and II (combined) total changes from $3,461,055.00 to $3,594,038.00.

OMPRO certifies that (1) this claim is made in good faith, (2) the supporting data are accurate and complete to the best of OMPRO's knowledge and belief and (3) the amount requested accurately reflects the contract adjustments for which OMPRO believes the government is liable.

Sincerely,

OREGON MEDICAL PROFESSIONAL REVIEW ORGANIZATION

Robert A. Berry
President

RAB:jb
Enc.
cc: Larry Camp, Region X
Faye Gilbarg

DEPARTMENT OF HEALTH & HUMAN SERVICES

Memorandum

Date: August 1, 1985

From: Trudi Galblum [HCFA Employee]

Subject: KFMC Monitoring Visit--July 24-26, 1985
Quality Assurance

To: Files: KS.7

The purpose of this review was to determine whether KFMC was performing quality assurance review as described in the Review Plan and to obtain some sense of the Foundation's commitment to aggressive quality assurance. Discussions on quality were held with Mike Speight, Diana Mallott, and Dr. Rex Stone.

In general, quality assurance review appears to conform to the Review Plan outline. Review comes under two categories: objectives and generic. Cases which fall into any one of the five quality objective categories are screened out (100%) for retrospective review. Although IM 85-2 permits elimination of admission and DRG validation review for these cases, KFMC is still doing admission review on quality cases. All cases reviewed primarily for reasons other than quality are screened against generic quality assurance guidelines.

If the reviewer detects a potential problem, the case is referred to the physician reviewer. The physician reviewer (PR) decides whether the case warrants referral to the Quality Assurance Committee (QAC) and/or the RO (e.g., premature discharges). Nothing has been referred to the RO to date other than the premature discharge cases.

Cases referred to the PR by the reviewer are noted on some of the "Monthly PRO Activity Reports" which are contained in the provider files in Topeka. This does not appear, however, to be a consistent practice among reviewers. The Wichita Office keeps a manual log of all cases referred to the QAC.

Quality Assurance Committee

The QAC meets quarterly, with case referral coordinated by Ms. Jeannie Broker in Wichita. Broker refers cases to the appropriate QAC subcommittee. Subcommittees are organized by medical specialty. The subcommittee makes a recommendation whether to refer the case to the full QAC. Although PRs and subcommittees are authorized to take educational action, recommend sanction, etc. at their own level, in practice, almost all cases get referred to the QAC. This seems to be due to individual practitioners' reluctance to single out other peers for discipline.

I requested that several quality assurance case files be provided to me for review. Four were delivered from Wichita on July 25. These came with a cover page summary of the nature of the case, process of review, and final disposition. A copy of the medical record and correspondence related to the cases were also attached. Three of the cases reviewed resulted in a "no-no" letter to the attending, advising of the need for better documentation or making clinical suggestions. A fourth case, determined to be a premature discharge, was referred to the RO.

I also reviewed the minutes of the QAC meetings since the PRO was established. Meetings reflect discussion of admission criteria, procedure changes (e.g., attending physician contact procedures--telephone or letter; when to refer an MI death to the QAC vs. when the PR can certify it), reporting of status of various corrective action plans, possible future study topics, and discussion and recommendation about QA cases.

Changes in Review Plan

I met with Dr. Stone to learn more about his problems and concerns regarding quality assurance. The first issue he raised was that too many cases were being referred to the full QAC. This workload problem appears to have been the catalyst for indepth rethinking of the QA process. Dr. Stone and Jeannie Broker have been working on some review plan changes which they are planning to propose to Larry Pitman and the Board.

Under the revised plan, only the more serious quality problems would be referred to the full QAC. For example, problems with documentation would be handled at a lower level. Problems would be stratified on four levels, with only levels 2-4 or 3-4 going to the QAC. The stratification would be made according to a generic list of adverse patient occurances. A review board of about five physicians would meet monthly or bimonthly to recommend handling of the cases. Not all cases would result in a letter to the physician as well as the hospital. There is apparently some ill will from physicians who have received letters that their hospitals also received letters. The new QA Review Plan would include putting the cases into a computer system so that patterns and recurrences could be detected. First time letters concerning less serious quality problems would only be sent to the attending physician.

The stratification Dr. Stone was working on was as follows:

(1) Potential for causing adverse occurance, but nothing actually happened.
(2) A minor, short term adverse reaction occurred. Recovery time and resulting costs were minimal.
(3) Increased morbidity resulting in longer LOS and more resource use.
(4) Mortality

During our exit conference, we told Larry Pitman and Gary Zook that we supported Dr. Stone's efforts in this direction. We were particularly supportive of the idea of automating the results of the new review process, which would enable KFMC to better identify patterns of inappropriate care. Larry said he also supports this initiative. Exclusive of these major changes, we told Larry that we thought more analysis and application of the logs kept in Wichita would permit KFMC to identify more problems. Larry will keep us informed about the progress of efforts in this area.

Other QA Topics

(1) Dr. Stone has given some thought to future objectives. He wrote specialty societies last December, which led to the criteria changes last February. That interchange also led to the cardiologists suggesting a bypass study. Dr. Stone also expressed some interest in expanding the readmission review to 14 days, evaluation of discharge screens to prevent premature discharge, and some surgeries.

(2) Diana Mallott described some physician reviewer workshops which have proved popular and also provide physicians with 6 hours CME. The workshops basically educate the PRs on the conduct of review. KFMC has videotapes of the workshops.

(3) Diana also developed a PR Manual. This is in draft and she will send a copy to the RO upon completion.

IV. KANSAS FOUNDATION FOR MEDICAL CARE QUALITY ASSESSMENT PROGRAM

OBJECTIVE

- To assess the medical care provided to eligible patients to assure that such care meets professionally recognized standards of quality.

SCOPE

Quality assessment will be conducted on all cases subject to pre-admission and concurrent review.

CRITERIA

Identification of any of the following adverse patient occurrences requires referral to a KFMC Physician Reviewer:

1. Admission for complication of previous hospitalization
2. Hospital - incurred incident
3. Unplanned return to surgery
4. Unplanned removal, injury or repair of organ or structure in:
    1) surgery
    2) invasive procedure
5. Nosocomial infection
6. Anesthesia complication
7. Inadequate physician documentation (as required in KFMC guidelines)
8. Neurological deficit not present on admission
9. Death unexpected
10. Blood transfusion not clinically indicated
    1) HGB-10
    2) HCT-30
11. Tissue diagnosis doesn't match preoperative diagnosis
12. Antibiotic for other than matched culture/sensitivity
13. Significantly abnormal lab, x-ray or other test results are not treated or documented by the physician
14. Radiologic diagnosis does not match diagnosis of attending physician
15. Other compllications
16. Medication variation
    1) incorrect dosage
    2) incorrect interval
17. Inappropriate medication prescribed for patient's clinical condition
18. Clinically substantiated condition not treated
19. Clinically unsubstantiated condition not treated

Reporting Date: 8 / 1 / 85

NDHCRI INCIDENCE REPORT TO REGIONAL OFFICE

Patient Name: ____________________ HIC NO.. ___________ Age: 76

Admit Date: 1 / 25 / 85 Hosp. Name [redacted] MPR No. 35-_____

Physician Name: ____________ ___ M.D. License No.: __________

Reviewer Numbers: R.S. [redacted] P.A. [redacted] Reviewed: 7 / 2 / 85

Incidence Type:

___A. Readmission Subsequent to a Pre-mature Discharge
_X_B. Transfer Of a Questionable Nature
___C. Hospital Initiated Denial Not Reported on Monthly List
___D. Inappropriate Hosp. Init. Den. Issued Prior to DRG ALOS

(Narrative description of the problem or discrepancy using as accurate direct language as possible. Use physicians orders and physician advisor notes for quotations where possible.)

This case involves a 76 year old male patient who was admitted to the hospital 1/1-/85 at which time a bilateral amputation of feet was done due to gangrene. The patient was transferred to swing bed on 1/25/85 for post-operative care. The patient was receiving IV fluids, IV Lasix and a Jackson Pratt drain was in place. At the time of transfer the patient was experiencing respiratory difficulty. There were rhonchi in the chest. The patient was having episodes of Cheyne-Stoke's repirations. The patient's urine was concentrated and output was decreased. The patient had multiple subcutaneous hemorrhages. The patient expired 1/27/85 in the swing bed. The case was referred to a Physician Advisor as a transfer of questionable nature. The Physician Advisor's comments follow: "It is felt from the patient's description in the doctor's notes for 1/25/85, the date the patient was transferred to the swing bed, that the patient still needed acute care in the hospital. Please refer to the Regional Office."

Distribution - Type	A B C D
NDHCRI	A B C D
Regional Office	A B C D
Hospital	A B C D
Attending Physician	A B C D
Fiscal Intermediary	D
Patient	D

Reporting Date: _8_/_1_/_85_

NDHCRI INCIDENCE REPORT TO REGIONAL OFFICE

Patient Name:______________________ HIC NO.:___________ Age:_70_

1 15 85
Admit Date:_2_/_07_/_85_ Hosp. Name____________ MPR No.35-_____

Physician Name:_____ __________ M.D. License No.:__________

Reviewer Numbers: R.S.[redacted] P.A.[redacted] Reviewed _7_/_19_/_85_

Incidence Type:

_X_A. Readmission Subsequent to a Pre-mature Discharge
___B. Transfer Of a Questionable Nature
___C. Hospital Initiated Denial Not Reported on Monthly List
___D. Inappropriate Hosp. Init. Den. Issued Prior to DRG ALOS

(Narrative description of the problem or discrepancy using as accurate direct language as possible. Use physicians orders and physician advisor notes for quotations where possible.)

This patient was admitted on 1/15/85 for a subtotal gastrectomy. The penrose drain had large amounts of bile colored drainage. The penrose was removed on 1/23/85. The nurses' notes record 4 x 4's soaked with bile colored fluid and flatus from penrose site right up to discharge. The Physician Advisor (PA) felt the discharge was premature as it resulted in a readmission on 2/7/85 with an abscess of the abdominal wall. The PA raised the following concerns in explaining the bile colored drainage: "inadequate closure of the duodenal stump, a leaking gastrojejunal anastamosis or possible nick of common duct in extensive duodenal dissection as described in operative report". The PA questioned the practice of doing itinerant surgery on a case complicated by massive adhesions from previous surgery and also the fact that there is no documentary of the operating surgeon having seen the patient post-operative on 1/15/85. The PA felt this patient should have been operated on in a hospital where the surgeon could do post-op care. With such massive drainage, a second operation may have been necessary to find the site.

Distribution - Type	A	B	C	D
NDHCRI	A	B	C	D
Regional Office	A	B	C	D
Hospital	A	B	C	D
Attending Physician	A	B	C	D
Fiscal Intermediary				D
Patient				D

Reporting Date: 08 / 01 / 85

NDHCRI INCIDENCE REPORT TO REGIONAL OFFICE

Patient Name:____________________ HIC NO.:__________ Age: 87

Admit Date: 3 / 18 / 85 Hosp. Name___________ MPR No.35-_____

Physician Name:__________________ M.D. License No.:_________

Reviewer Numbers: R.S. [redacted] P.A. [redacted] Reviewed: 7 / 8 / 85

Incidence Type:

X A. Readmission Subsequent to a Pre-mature Discharge
___B. Transfer Of a Questionable Nature
___C. Hospital Initiated Denial Not Reported on Monthly List
___D. Inappropriate Hosp. Init. Den. Issued Prior to DRG ALOS

(Narrative description of the problem or discrepancy using as accurate direct language as possible. Use physicians orders and physician advisor notes for quotations where possible.)

This case involves an 87 year old female who was admitted to the hospital on 3/18/85 for treatment of pneumonia. The patient was discharged 3/23/85 with a temperature of 100.4. The chest x-ray done on 3/21/85 showed an increase in the pneumonia with progression of infiltrate in the right mid and left lower lung and a new infiltrate developed in the right lower lung. The patient was readmitted on 3/30/85 with a temperature of 101.2. The case was referred to a Physician Advisor as a questionable premature discharge. The Physician Advisor's comments follow: "It is felt that the first admission resulted in premature discharge as the patient was still febrile and had further progression in the chest x-ray findings two days prior to discharge. Please refer to the Regional Office."

Distribution - Type	A B C D
NDHCRI	A B C D
Regional Office	A B C D
Hospital	A B C D
Attending Physician	A B C D
Fiscal Intermediary	D
Patient	D

Reporting Date: 8 / 1 / 85

NDHCRI INCIDENCE REPORT TO REGIONAL OFFICE

Patient Name:____________________ HIC NO.:___________ Age: 89

Admit Date: 3 / 17 / 85 Hosp. Name___________ MPR No.35-_____

Physician Name:__________________ M.D. License No.:__________

Reviewer Numbers: R.S. [redacted] P.A. [redacted] Reviewed: 7 / 2 / 85

Incidence Type:

X A. Readmission Subsequent to a Pre-mature Discharge
X B. Transfer Of a Questionable Nature
___C. Hospital Initiated Denial Not Reported on Monthly List
___D. Inappropriate Hosp. Init. Den. Issued Prior to DRG ALOS

(Narrative description of the problem or discrepancy using as accurate direct language as possible. Use physicians orders and physician advisor notes for quotations where possible.)

This case involves an 89 year old female who was admitted to the hospital on 2/22/85 because of syncope and Staph Pneumonia. The patient was transferred to a swing bed on 3/4/85. The patient was readmitted to the hospital on 3/10/85 with pneumonia. The patient again was discharged to a skilled nursing home on 3/17/85. At the time of discharge the Hgb was 9.7 and the chest x-ray showed only partial resolution. On the day of discharge the patient was running a low grade temperature. The patient was readmitted on 3/17/85 (the same day the patient was discharged) for treatment of pneumonia and discharged 3/25/85. The case was referred to a Physician Advisor for questionable premature discharge and transfer of questionable nature. The Physician Advisor's comments follow: "The patient was discharged and readmitted with fever on the same day. The patient should have remained in acute care on 3/17/85. Please refer to the Regional Office."

Distribution - Type	A B C D
NDHCRI	A B C D
Regional Office	A B C D
Hospital	A B C D
Attending Physician	A B C D
Fiscal Intermediary	D
Patient	D

Annual Report PO-3
AUS-17

THE SECRETARY OF HEALTH AND HUMAN SERVICES
WASHINGTON, D.C. 20201

AUG 1 1985

The Honorable George Bush
President of the Senate
Washington, D.C. 20510

Dear Mr. President:

I am respectfully submitting the report required by Section 1161 of the Social Security Act which requires the Secretary of the Department of Health and Human Services to submit to Congress a full and complete report on the administration, impact, and cost of the Utilization and Quality Control Peer Review Organization (PRO) program during the preceding fiscal year.

FY 1984 was one of start-up and implementation of the PRO program. Thirty-six PRO contracts had been signed by the end of FY 1984. The remaining 18 PRO contracts were signed by November 15, 1984. This report describes (1) PRO review in PPS and in waivered and exempt States; (2) the status of PRO implementation; (3) the number and type of hospitals under PRO review; (4) the number of PRO reviews conducted; (5) the methods of reimbursement for PRO contracts; (6) PRO Sanction activity; (7) the cost of PRO review; (8) evaluation and review criteria; and (9) the status of the PRO regulations.

The estimated cost to prepare this report is $800.

I am sending a similar letter to the Speaker of the House of Representatives.

Sincerely,

Margaret M. Heckler

Margaret M. Heckler
Secretary

Enclosures

Annual Rep.
PO:
XV5,

THE SECRETARY OF HEALTH AND HUMAN SERVICES
WASHINGTON, D.C. 20201

AUG 1 1985

The Honorable Thomas P. O'Neill, Jr.
Speaker of the House of Representatives
Washington, D.C. 20515

Dear Mr. Speaker:

I am respectfully submitting the report required by Section 1161 of the Social Security Act which requires the Secretary of the Department of Health and Human Services to submit to Congress a full and complete report on the administration, impact, and cost of the Utilization and Quality Control Peer Review Organization (PRO) program during the preceding fiscal year.

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Sincerely,

Margaret M. Heckler

Margaret M. Heckler
Secretary

Enclosures

DEPARTMENT OF HEALTH & HUMAN SERVICES
Health Care
Financing Administration

Memorandum

Date JUN 21 1985

From Carolyne K. Davis, Ph.D.
Administrator
Health Care Financing Administration

Carolyne K. Davis

Subject Report to Congress: FY 1984 Utilization and Quality Control Peer Review Organization (PRO) Program Implementation Report (Section 1161 of the Social Security Act)—ACTION

To The Secretary
Through: US
ES DARS

The Tax Equity and Fiscal Responsibility Act of 1982 amended Section 1161 of the Social Security Act to require the Secretary of Health and Human Services to submit to Congress a full and complete report on the administration, impact, and cost of the PRO program during the preceding fiscal year.

FY 1984 was one of start-up and implementation for the PRO program. Thirty-six PRO contracts had been signed by the end of FY 1984. The remaining 18 PRO contracts were signed by November 15, 1984. This report describes (1) PRO review in PPS and in waivered and exempt States; (2) the status of PRO implementation; (3) the number and type of hospitals under PRO review; (4) the number of PRO reviews conducted; (5) the methods of reimbursement for PRO contracts; (6) PRO Sanction activity; (7) the cost of PRO review; (8) evaluation and review criteria; and (9) the status of the PRO regulations.

We have prepared the attached letters for your signature which will transmit the report to the appropriate congressional designees.

The estimated cost to prepare this report is $800.

2 Attachments

Tab A: Letter to Honorable George Bush
Tab B: Letter to Honorable Thomas P. O'Neill, Jr.

DEPARTMENT OF HEALTH & HUMAN SERVICES
Office of the Secretary
Washington, D.C. 20201

MEMORANDUM FOR THE SECRETARY JUL 24 ---

THROUGH: US
ES
DES

FROM: Neil R. Powe, M.D.
Policy Specialist/Health

SUBJECT: Report to Congress Concerning the Implementation of the Peer Review Organization (PRO) Program During FY 1984

Background

The Tax Equity and Fiscal Responsibility Act of 1982 amended the Social Security Act to require the Secretary to submit to Congress a full and complete report on the administration, impact, and cost of the PRO program during the preceding fiscal year.

As you know, PRO's are responsible for assuring that Medicare patients receive medically necessary and reasonable care in the appropriate setting and of a professionally accepted standard of quality. This is done by review of care provided in hospitals paid by Medicare.

Summary and Highlights of the Report

- PRO review in states under PPS and in waivered and exempt states

  The type of review activities and the objectives that PROs must meet vary according to whether the PRO is in a state that is in Medicare's prospective payment system (PPS) or in a state not under the prospective payment system. Required PRO review activities in states under PPS during FY 1984 were 1) review of the necessity of admissions for procedures that can be performed safely and effectively on an outpatient basis, 2) review of readmissions for detection of premature discharge or poor quality care, 3) review of cardiac pacemaker reimplantation, 4) review of transfers, 5) admission pattern monitoring, 6) review of admissions and days of care in specialty hospitals, 7) review of every 20th admission, 8) review and monitoring of hospital denials and notices of noncoverage, 9) review of diagnostic and procedural information and every outlier case. In addition, PRO's must also achieve certain admission, procedure and patient care quality objectives.

  PRO review activities for hospitals in waivered states (NJ, MA, MD, NY) and exempt areas (U.S. Virgin Islands, Guam, American Samoa, Trust Territories and Puerto Rico) are different because the various reimbursement systems create different incentives. Review activities are created to achieve the objectives necessary for high quality health care and payment of necessary and appropriate services in the specific systems.

- The status of PRO implementation

  FY 1984 was the start up and implementation year for the PRO program. Thirty-six PRO contracts had been signed by the end of FY 1984. The remaining 18 contracts were signed by November 15, 1984.

- The number and type of hospitals under PRO review

  A total of 6663 hospitals are under review. These include 6089 general acute care facilities, 540 psychiatric facilities, 28 rehabilitation facilities and 6 alcohol detoxification facilities.

- Number of PRO reviews conducted

  In FY 1984 PRO review was completed for 248,416 Medicare discharges in 36 states. This number is small because only 9 PRO's were in operation by July 1, 1984. Thirty percent of all Medicare discharges are expected to be reviewed by PRO's each year.

- Methods of reimbursement for PRO contracts

  Fifty-three of the fifty-four PRO's are reimbursed on a fixed price basis. One PRO is paid on a cost reimbursement basis because it is the Medicare fiscal intermediary for Idaho and this method of reimbursement provides consistency for its two responsibilities.

- PRO sanction activity

  No sanctions were imposed in FY 1984 on practitioners or providers because the earliest PRO review did not begin until the last quarter of FY 1984. Sanction activities have begun and submission of reports to the Office of the Inspector General, HHS is expected soon.

- Cost of PRO review and evaluation of PRO contracts

  The total cost of PRO contracts was $301,594,306. The evaluation criteria for proposals and awarding of PRO contracts placed the most weight on the objectives and required review activities. Criteria for selection of cases for PRO review were developed using nationally recognized criteria sets adapted to meet the needs of PPS, PRO review requirements and the typical practices in the local area.

0 Status of regulations

Five regulations have been published for implementation of the PRO program. They involve 1) designation of PRO areas and definitions of eligible organizations, 2) conduct of review and Medicaid relationships with PRO's, 3) reconsideration and appeals of PRO determinations, 4) confidentiality of information obtained and developed by a PRO and 5) the sanction process. The first was published on February 27, 1984. The others were published on April 17, 1985.

Cost of the Report

The estimated cost to prepare this report is $800.

Recommendation

We recommend that you transmit this Report to Congress.

Decision

Approved ____________ Disapproved ____________ Date ________

Other ____________

REPORT TO CONGRESS

Implementation of the Utilization and Quality Control Peer Review Organization (PRO) Program in Fiscal Year 1984

A. Introduction

PROs are responsible for assuring that the care provided to all Medicare patients is medically necessary and reasonable, is provided in the appropriate setting, and meets professionally accepted standards of quality. PROs review care provided in hospitals paid by Medicare either under the prospective payment system (PPS) or other reimbursement arrangement. The type of required review activities and the objectives that PROs must meet vary according to whether the PRO is in a PPS or non-PPS State.

PPS Review

The PPS endeavors to change hospital behavior through financial incentives under Medicare. The PROs act as a safeguard to assure that as certain behavioral changes occur in response to PPS incentives, the quality of health care provided to Medicare beneficiaries remains high and that Medicare pays only for necessary and appropriate services.

The following were the PRO required review activities during fiscal year 1984:

(1) Preadmission review of every elective case for specified procedures or diagnoses selected by the PRO. This review allows PROs to ensure the necessity of admissions for procedures that can, in many cases be done safely and effectively on an outpatient basis.

(2) Review of admissions occurring within 7 days of a discharge. This allows PROs to identify any situations in which readmissions may be caused by premature discharge or poor quality care during the initial admission.

(3) Review of every permanent cardiac pacemaker implant and reimplant.

(4) Review of transfers from a PPS hospital to either another hospital, or to a PPS-exempt psychiatric, rehabilitation, or alcohol detoxification unit, or to a swing bed, to make sure that the transfer was medically justified.

(5) Monitoring of hospitals to determine whether admissions have risen over time in an aberrant fashion and to determine the cause (Admission Pattern Monitoring).

(6) Review of admissions and days of care in specialty hospitals and distinct part psychiatric, alcohol detoxification and rehabilitation units.

(7) Admission review of every 20th admission not otherwise reviewed, as an overall check on the quality and necessity of admissions.

(8) Review and monitoring of hospital denials and notices of noncoverage issued under Prospective Payment System regulations (42 CFR 412.42), to make sure the denials and notices are correct and adequately inform all parties of their rights.

(9) Review and validation of diagnostic and procedural information supplied by hospitals and review of every case involving a day or cost outlier.

PROs must also achieve admission and procedure objectives in the following categories:

(1) Reduce admissions for procedures that could be performed effectively and with adequate assurance of patient safety in an ambulatory surgical setting or on an outpatient basis.

(2) Reduce the number of inappropriate or unnecessary admissions or invasive procedures for specific DRGs.

(3) Reduce the number of inappropriate or unnecessary admissions or invasive procedures by specific practitioners or in specific hospitals.

In addition, PROs must achieve significant improvement in patient care quality by achieving quality objectives in the following categories:

(1) Reduce unnecessary hospital readmissions resulting from substandard care provided during the prior admission.

(2) Assure the provision of medical services which, when not performed, have significant potential for causing serious patient complications.

(3) Reduce the risk of mortality associated with selected procedures and/or conditions requiring hospitalization.

(4) Reduce unnecessary surgery or other invasive procedures.

(5) Reduce avoidable postoperative or other complications.

PRO Review in States With Waivers or Exemptions from PPS Review

At the end of FY 1984, four States were conducting Medicare hospital reimbursement under waivers of PPS. These States were New Jersey, Maryland, Massachusetts and New York. In addition, the following areas were exempt from PPS. The exempt areas were Puerto Rico, the U.S. Virgin Islands, and Guam, American Samoa, and the Trust Territories of the Pacific. The following is a description of the reimbursement systems in place in each of these PRO areas, the financial incentives for hospitals, and the type of review system established to address the particular concerns of each of these reimbursement systems.

New Jersey

The reimbursement system in New Jersey provides for prospective case-mix based reimbursement rates. The PRO review system is identical to that for PPS hospitals.

Massachusetts

The Massachusetts reimbursement system caps total hospital revenue within defined "corridors" of utilization. The incentive for Massachusetts hospitals under this system is to stay within the corridor and not go above or below the limit of the corridor.

Because hospitals in Massachusetts have an incentive to reduce utilization, we designed the review system to assure that the quality of care is preserved. The PRO must achieve quality objectives in the areas of underutilization of hospital services, inappropriate surgery, unnecessary transfers, reduction in the risk of mortality associated with selected procedures and/or conditions requiring hospitalization, and avoidable postoperative and other complications. The Massachusetts PRO also has one admission objective (to reduce unnecessary and inappropriate admissions) because unnecessary or inappropriate care can result in quality problems. The PRO also reviews admissions above or below the utilization corridor and certain ambulatory surgery and emergency room visits. They do not review transfers or readmissions because there is no incentive in the reimbursement system to increase admissions through transfers or readmissions. DRG validation is not relevant in Massachusetts because the system makes no use of DRGs; and, thus, outliers do not exist.

Maryland

Under the Maryland reimbursement system, all hospitals and all payors have their costs regulated by the Maryland Health Services Cost Review Commission which sets rates for each category of cost. In addition, some hospitals are required to and others choose to participate in the Guaranteed Inpatient Revenue Program (GIR), which establishes a target cost per admission. If GIR hospitals' actual costs are below this target at the end of the year, they keep the difference between the target and actual costs. Most Maryland hospitals (63 percent) and almost all large hospitals are under the GIR system.

The PRO review system in GIR hospitals focuses on admissions and coding validation because these hospitals get paid on a per admission basis rather than for actual costs incurred. In non-GIR hospitals, review is focused on admissions, length of stay, and ancillary service use because hospitals are paid on a cost-per-admission basis.

The Maryland PRO must perform admission pattern monitoring, cardiac pacemaker review and preadmission review as required in PPS States. In addition, the PRO must --

- achieve one objective related to reducing the use of unnecessary ancillary services;
- perform admission review on 15% of Medicare discharges;
- perform length-of-stay review on 2.5% of Medicare discharges, primarily in non-GIR hospitals;
- perform coding validation on 3% of Medicare discharges in GIR hospitals; and
- achieve five quality objectives, which are similar to those required in PPS States.

New York

The State operates under a cost control system known as the New York Prospective Hospital Reimbursement Methodology. The New York reimbursement system limits payment to a prospective per diem rate for each day of hospitalization, regardless of the actual costs incurred.

Because New York hospitals are paid on a per diem basis, review is caused primarily on the patients' length of stay in the hospital, in addition to admission review. The New York PRO must perform admission pattern monitoring, preadmission review and pacemaker review as required in PPS States. Also, the PRO must --

- review 5% of admissions;
- achieve an admission objective to reduce unnecessary and inappropriate admissions;
- perform coding validation on 3% of Medicare discharges;
- perform length-of-stay review on 15% of Medicare discharges; and

- achieve quality objectives to reduce the risk of mortality associated with selected procedures and/or conditions requiring hospitalization; reduce unnecessary surgery; reduce avoidable postoperative or other complications; and reduce inappropriate drug therapy or other key deficiencies in patient management.

U.S. Virgin Islands and Guam, American Samoa, Trust Territories

These areas are exempt from PPS. Medicare reimbursement for the Virgin Islands, Guam and Samoa is under the provisions of the Tax Equity and Fiscal Responsibility Act of 1982 (TEFRA). The TEFRA sets limits based on the cost per discharge of hospitals, grouped according to similar characteristics, and also sets a target rate for each provider based on its reimbursable cost per discharge in previous years. The Trust Territories are exempt from TEFRA and PPS and are reimbursed on a retrospective cost basis. Hospital reimbursement in these areas is linked very closely to hospital expenditures.

Because there are so few admissions (under 2000 for FY 1983), sampling or focused review is not possible. Therefore, PROs for these areas review 100% of Medicare admissions on a preadmission, concurrent or retrospective basis. In addition, these PROs perform the following activities:

- admission pattern monitoring;
- review of all pacemaker implants and reimplantations; and
- achievement of quality objectives in one or more of the following areas: reduce the risk of mortality associated with selected procedures and/or conditions requiring hospitalization; reduce unnecessary surgery or other invasive procedures; reduce avoidable postoperative or other complications; reduce inappropriate drug therapy or other key deficiencies in patient management.

Puerto Rico

Hospitals in Puerto Rico are reimbursed on a reasonable cost basis for inpatient care provided to Medicare beneficiaries, within the constraints of TEFRA. Because it is a larger area than the other exempt areas, the PRO in Puerto Rico focuses its efforts on the review of 20 percent (rather than all) of admissions and lengths of stay. The PRO in Puerto Rico will review all pacemaker implants and reimplantations. The PRO must also —

- perform admission pattern monitoring;
- perform preadmission review of at least five procedures;
- achieve an admission objective to reduce inappropriate or unnecessay admissions; and

- achieve quality objectives in one or more of the following areas: reduce the risk of mortality associated with selected procedures and/or conditions requiring hospitalization; reduce unnecessary surgery or other invasive procedures; reduce avoidable postoperative or other complications; reduce inappropriate drug therapy or other key deficiencies in patient management.

B. Status of Implementatic

Thirty-six PRO contracts had been signed by the end of FY 1984. The remaining 18 PRO contracts were signed by November 15, 1984. The following is a list of all 54 PRO areas, the date each contract was signed, and the effective date of each contract. Those areas marked with an asterisk (*) were awarded contracts after September 30, 1984.

PRO CONTRACTS SIGNED

Area	Date Signed	Effective Date
Alabama	07/10/84	07/01/84
Alaska	09/15/84	11/01/84
Arizona	07/30/84	08/01/84
Arkansas	06/25/84	07/01/84
California	09/24/84	10/01/84
Colorado	06/27/84	08/01/84
*Connecticut	10/19/84	11/01/84
Delaware	07/06/84	07/01/84
*D.C.	10/18/84	11/01/84
Florida	07/13/84	08/01/84
Georgia	07/25/84	08/01/84
*Guam	11/09/84	11/15/84
*Hawaii	11/09/84	11/15/84
*Idaho	11/09/84	11/15/84
*Illinois	10/19/84	11/01/84
Indiana	08/09/84	08/01/84
Iowa	07/19/84	07/01/84
Kansas	06/29/84	07/01/84
Kentucky	06/22/84	07/01/84
Louisiana	07/27/84	08/01/84
*Maine	10/19/84	11/01/84
*Maryland	10/18/84	11/01/84
*Massachusetts	10/17/84	11/01/84
*Michigan	10/12/84	10/01/84

Area	Date Signed	Effective Date
Minnesota	07/27/84	08/01/84
Mississippi	06/28/84	07/01/84
Missouri	07/30/84	08/01/84
Montana	07/17/84	07/01/84
Nebraska	08/27/84	10/01/84
Nevada	07/11/84	07/01/84
New Hampshire	07/12/84	07/01/84
*New Jersey	10/09/84	10/01/84
New Mexico	08/02/84	08/01/84
New York	08/22/84	09/01/84
North Carolina	07/25/84	08/01/84
North Dakota	07/25/84	08/01/84
*Ohio	10/12/84	10/01/84
*Oklahoma	10/15/84	10/01/84
Oregon	07/23/84	08/01/84
*Pennsylvania	10/13/84	10/01/84
Puerto Rico	09/07/84	09/01/84
Rhode Island	07/20/84	08/01/84
South Carolina	06/21/84	07/01/84
*South Dakota	10/10/84	10/01/84
Tennessee	06/22/84	07/01/84
*Texas	10/03/84	10/01/84
Utah	06/26/84	07/01/84
*Vermont	10/12/84	11/01/84
*Virginia	10/01/84	10/15/84
Virgin Islands	08/16/84	09/01/84
Washington	09/15/84	10/01/84
West Virginia	06/27/84	07/01/84
Wisconsin	07/26/84	07/01/84
Wyoming	07/17/84	07/01/84

C. Health Care Institutions and Practitioners Subject to PRO Review

Currently, PRO contracts cover review of all Medicare inpatient hospital admissions and services. The following is a listing of health care facilities in each PRO area as of September 30, 1984. The facilities are categorized by type of facility (general acute, alcohol detoxification, rehabilitation, psychiatric).

Hospitals Under PRO Review

PRO Area	Acute	Alcohol Detoxification	Rehabilitation	Psychiatric	Total
Alaska	131			6	137
Alabama	24			2	26
Arizona	71			5	76

PRO Area	Acute	Alcohol Detoxification	Rehabilitation	Psychiatric	Total
Arkansas	100			3	103
California	499	1		37	537
Colorado	82		3	6	91
Connecticut	42			9	51
Delaware	7		1	2	10
D.C.	11			2	13
Florida	226			23	249
Georgia	169			19	188
Guam	1				1
Hawaii	22			2	24
Idaho	47			4	51
Illinois	245			15	260
Indiana	122			15	137
Iowa	130			4	134
Kansas	145			7	152
Kentucky	107			10	117
Louisiana	145			10	155
Maine	46			2	48
Maryland	61			11	72
Massachusetts	148			10	158
Michigan	207			9	216
Minnesota	173			24	197
Mississippi	118			1	119
Missouri	162	2		11	175
Montana	64				64
Nebraska	101			4	105
Nevada	26	2		3	31
New Hampshire	28			2	30
New Jersey	100			11	111
New Mexico	51			1	52
New York	283			35	318
North Carolina	138			14	152
North Dakota	54			1	55
Ohio	205			16	221
Oklahoma	133			8	141
Oregon	75			5	80
Pennsylvania	231		14	29	274
Puerto Rico	55			1	56
Rhode Island	16			3	19

PRO Area	Acute	Alcohol Detoxification	Rehabilitation	Psychiatric	Total
South Carolina	73		7		80
South Dakota	63			1	64
Tennessee	148			11	159
Texas	496			22	518
Utah	41			1	42
Vermont	16			2	18
Virginia	107		2	16	135
Virgin Islands	2				2
Washington	106	1		5	112
West Virginia	66		1	2	69
Wisconsin	142			17	159
Wyoming	28			1	29
Total	6089	6	28	540	6663

D. Number of Beneficiaries Subject to PRO Review in FY 1984

In the last quarter of FY 1984, PRO review was completed for 248,416 Medicare discharges in 36 States. Since only nine PROs were in operation by July 1, 1984, these figures are not representative of the volume of PRO review expected for the full year. We estimate that approximately 30 percent of all Medicare discharges will be reviewed by PROs nationwide.

E. Methods of Reimbursement for PRO Contracts

There are two basic types of funding available for government contracts: cost reimbursement and fixed price. Cost reimbursement contracts pay the contractor for all reasonable costs incurred. The contractor is paid for its "best effort" in meeting the objectives of the contract. This form of contract requires detailed monitoring of the contractor's efforts in carrying out the obligations of the contract. We determined that cost reimbursement contracts would not generally meet the intent of the Medicare and PRO statutes for two reasons. First, the Medicare statute (Section 1866(a)(1)(F) of the Social Security Act) stipulates that PROs are to be funded on a rate per review. Second, the intensive scrutiny of internal operations inherent in cost contracts would be contrary to the intent of Congress that there be limited Government intervention in the daily activities of PROs.

Fixed-price contracts require clear, complete and accurate specifications, necessitating a defined set of deliverables. The amount of funding for the contract is fixed for the term of the contract. A standard fixed-price contract does not require auditing of records during performance, and monitoring is based purely on the acceptance or rejection of the products specified in the contract. We determined that fixed price contract would be the most appropriate method to use to fund PROs.

Fifty-three of the fifty-four PROs are reimbursed on a fixed-price basis and receive monthly payments. The other PRO is also the Fiscal Intermediary for Idaho (Idaho Blue Cross) and is paid on a cost reimbursement basis in order to be consistent with the method of reimbursement used to finance its activities as a Medicare Fiscal Intermediary.

F. Sanction Activity

In FY 1984, PROs imposed no sanctions on practitioners or providers. The earliest PRO review began in July 1984. Pending publication of PRO regulations, PROs have been conducting sanction activities under the provisions of Section 1862 of the Act. We expect that PROs will begin to submit sanction reports in the near future to the Office of the Inspector General, HHS, which reviews these reports on behalf of the Secretary.

G. Cost of PRO Review

HCFA has signed two-year contracts with fifty-four PROs. We expect that there will be supplemental costs for items not included in the fixed price contracts and in cases where PROs increase the amount of their review or expand the types of review they perform. For example, sanctions and fraud and abuse activities are to be paid for on a cost basis. We will be expanding PRO review to the quality of care provided by HMOs and we may expand PRO review to other areas such as outpatient review and concurrent review of discharges. The following is a list of all 54 PRO areas and their Medicare contract amounts. PRO contracts in those areas marked with an asterisk (*) were signed after FY 1984, but prior to November 15, 1984.

Area	Amount
Alabama	$ 6,350,000
Alaska	650,000
Arizona	2,754,127
Arkansas	4,376,814
California	27,000,000
Colorado	3,140,000
**Connecticut	3,173,783
Delaware	694,242
*D.C.	599,886
Florida	14,340,000
Georgia	7,400,000
*Guam	226,661
*Hawaii	1,284,411
*Idaho	1,300,000
*Illinois	15,219,970
Indiana	7,449,120
Iowa	5,425,000
Kansas	4,279,054

Area	Amount
Kentucky	$ 6,500,000
Louisiana	5,200,000
**Maine	1,650,000
*Maryland	3,192,853
*Massachusetts	7,072,731
*Michigan	9,590,863
Minnesota	6,576,253
Mississippi	3,630,504
Missouri	9,000,000
Montana	1,195,600
Nebraska	3,094,569
Nevada	1,240,182
New Hampshire	1,255,000
*New Jersey	8,100,000
New Mexico	1,437,832
New York	20,200,000
North Carolina	7,760,805
North Dakota	1,462,455
*Ohio	13,500,000
*Oklahoma	4,700,000
Oregon	3,461,055
*Pennsylvania	18,260,500
Puerto Rico	1,575,000
Rhode Island	1,299,846
South Carolina	3,684,448
*South Dakota	1,475,000
Tennessee	7,481,244
*Texas	18,500,000
Utah	1,403,808
*Vermont	633,085
*Virginia	6,074,527
Virgin Islands	440,000
Washington	4,525,000
West Virginia	3,084,000
Wisconsin	7,150,000
Wyoming	525,078
Total	$301,594,306

Although PROs were not required to perform Medicaid review in FY 1984, 19 PROs had private review contracts to review Medicaid services. The total amount expended under these contracts for review in FY 1984 was $4,300,012.(1). The following PROs have contracts to perform Medicaid review:

Arkansas
Colorado
Delaware
Iowa
Kentucky
Maryland
Massachusetts
Mississippi
Nevada
New Hampshire
New Mexico
North Dakota
Oklahoma
Oregon
South Carolina
South Dakota
Vermont
West Virginia
Wisconsin

H. Evaluation and Review Criteria

There are two types of criteria which are relevant to the PRO program: (1) the criteria that were used by HCFA in evaluating proposals and awarding PRO contracts; and (2) the criteria used by PROs to screen cases for review. In addition, we have developed criteria which will be used to monitor and evaluate PROs on an ongoing basis.

Evaluation Criteria

Proposals for PRO review in PPS States and in waivered and exempt areas were evaluated by HCFA based on seven criteria. The criteria was designed to place the most weight on the objectives and required review activities.

(1)	Understanding of the work to be performed by a PRO -	50 points
(2)	Specific objectives and required review activities related to admissions and quality of care -	600 points
(3)	Experience in conducting peer review, including length, type, and quality of experience -	150 points
(4)	Personnel, including educational background, professional experience and special qualifications -	200 points
(5)	Management plan that specifies the staffing and organizational structure for the contract -	100 points

---

(1)This is the total amount paid by States in FY 1984 for review of Medicaid services by PROs. In some instances, these organizations received their contracts before they were designated as PROs.

(6)	Points awarded to physician-sponsored organizations -	100 points
(7)	Price of the proposal -	300 points

Review Criteria

Review criteria are actually screening criteria which are chosen by PRO physicians and are used by non-physician reviewers to approve payment for cases which clearly meet accepted standards and to refer questionable cases to physician reviewers. Review criteria contain the generally recognized reasons which would justify a patient's admission to a hospital or the need for a surgical procedure. For purposes of assuring the quality of care provided, criteria also contain the generally recognized services and care which should be provided for specific diagnoses or procedures.

In developing their review criteria, PROs generally use nationally-recognized criteria sets adapted to meet the needs of the prospective payment system, PRO review requirements, and typical practices in the local area. The PRO screening criteria should not be viewed as medical standards which must be met in every case in order for PROs to approve Medicare payment. HCFA has the authority to review these criteria and to request changes. PRO physician reviewers, who are actively practicing physicians in the PRO area, make their determinations regarding the necessity, appropriateness and quality of care provided with regard to each questionable case primarily on the basis of their own knowledge, experience and training and on the basis of discussions with the attending physicians. Examples of review screening criteria are attached to this report at Tab A.

We have also attached to this report a summary of the objectives contained in all PRO review contracts (Tab C). The objectives indicate how under the contractual agreements PROs must commit themselves to achieving utilization and quality impact. The objectives also include methodologies used to accomplish this impact.

I. Status of Regulations

We have proposed five regulations for implementation of the PRO program. The Area Designation regulation was published in final form on February 27, 1984. The other four regulations were published as final regulations on April 17, 1985. Summaries of the contents of the regulations are attached to this report at Tab B.

Attachments

Tab A -Sample Review Criteria
Tab B -Summary of Regulations
Tab C -PRO Objective Summaries

SAMPLE REVIEW CRITERIA

TAB A

Postoperative Complications (Must be locally defined)

1. Sepsis (e.g., wound infection, abscess, bacteremia, septic phlebitis)
2. Hemorrhage
3. Wound dehiscence
4. Pulmonary complication (e.g., atelectasis, pneumonia, aspiration, embolus)
5. Cardiovascular complications (including thrombophlebitis)
6. Urinary tract infection
7. Anesthetic complications
8. Other complications (as defined locally or attributed to specific procedures)

Discharge Status

1. Alive

The following items must be defined locally:

2. Stable vital signs
3. Satisfactory condition of wound
4. Tolerating diet
5. Provision for follow-up care
6. Complications controlled
7. If a diagnosis of malignancy is confirmed, consultation with appropriate treatment specialists (surgeon, radiation oncologist or medical oncologist) for staging and management planning.

September 1979

CPT	ICD-9-CM
44950	47.0
44955	47.1
44960	

APPENDECTOMY

I. INDICATIONS FOR SURGICAL PROCEDURE

A. Acute Appendicitis
B. "Interval" appendectomy
C. Tumor of appendix
D. "Incidental" appendectomy to another operative procedure, (e.g., hysterectomy)

Indications for operation derived from the following suggested evaluation:

1. For acute appendicitis
   a. Except in children and the elderly, history of abdominal pain (usually mid-abdominal or periumbilical) associated with nausea or vomiting or anorexia and shift of pain to right lower quadrant, plus one or more of the following:
      (1) Right lower quadrant tenderness, rebound, or guarding
      (2) Rectal temperature of 100°F or above
      (3) Positive rectal exam for tenderness (right sided or midline)
      (4) White blood cell count over 10,000 with 80% or more polymorphonuclears
      (5) Persistence of symptoms for over 6 hours
      (6) Increase in symptoms during observation
   b. In children (generally below 8 years), acute abdominal pain developing in a previously well individual, associated with local or diffuse abdominal tenderness and leukocytosis
   c. In elderly patients, previously well, either:
      (1) Typical history or acute appendicitis (mid-abdominal pain, followed by vomiting and shift of pain to right lower quadrant); or
      (2) Localized right lower quadrant pain and tenderness
2. "Interval" appendectomy following an acute attack of appendicitis or drainage of appendiceal abscess
3. Tumor of appendix usually has the same presenting signs as acute appendicitis, but the presence of an appendiceal tumor is an adequate indication for appendectomy
4. "Incidental" appendectomy is indicated when, in the opinion of the surgeon, appendectomy can be performed without increased hazard to the patient

Screening Guidelines

1. Other causes for signs and symptoms should be ruled out, i.e.,urinary tract infection, urinary calculi, pelvic pathology in females by urinalysis, pelvic and rectal examination.

These sample criteria are for screening patient care for subsequent physician review only and do not constitute standards of care.

September 1979

APPENDECTOMY

Screening Guidelines (Continued)

- It is important to remember that the appendectomy may at times be justified by signs, symptoms and workup--even though not validated by the pathologist's report

II. LEVEL OF CARE REQUIRED

A. Inpatient facility
B. Length of stay: see statement on p. 7

III. POSTOPERATIVE COMPLICATIONS

A. See general comments on p. 15
B. Obstruction or ileus
C. Fecal fistula

IV. POSTOPERATIVE VALIDATION OF DIAGNOSIS

A. Surgeon's operative report
B. Pathologist's report of acute appendicitis, tumor, or acute exacerbation but not to include periappendicitis

V. DISCHARGE STATUS

A. See general comments on p. 15

Developed by: AMA General Surgery Criteria Committee
American College of Gastroenterology
American Society of Internal Medicine
American Gastroenterological Association

These sample criteria are for screening patient care for subsequent physician review only, and do not constitute standards of care.

September 1979

CPT
47600 47611
47605 47620
47610

CHOLECYSTECTOMY, With or Without Exploration of Bile Ducts

I. INDICATIONS FOR SURGICAL PROCEDURE

A. Acute cholecystitis
B. Cholelithiasis, with symptoms
C. Choledocholithiasis
D. Tumor of gallbladder

Indications for operation derived from the following suggested evaluation:

1. For acute cholecystitis
   a. History of one or more of the following:
      (1) right upper quadrant abdominal pain
      (2) nausea
      (3) vomiting
      (4) flatulence
      (5) chills
      (6) fever
      (7) pancreatitis with demonstrated gallstones; and
   b. Physical examination with findings of one or more of the following:
      (1) tenderness
      (2) palpable mass
      (3) fever over 101°(F)
2. Cholelithiasis demonstrated by radiologic examination with symptoms ranging from flatulence to severe biliary colic and referred pain
3. For choledocholithiasis, the same as for acute cholecystitis (see number 1 above) plus jaundice or history of jaundice
4. For tumor or polyp, radiologic examination demonstrating mucosal abnormality of gallbladder

Screening Guidelines

1. Appropriate liver tests should be performed
2. Cases which do not have gallstone or tumors should be subjected to physician review unless pathology report demonstrates acute cholecystitis

II. LEVEL OF CARE REQUIRED

A. Inpatient facility
B. Length of stay: see statement on p. 7

ICD-9-CM
51.21
51.22
51.41-51.49
51.51-51.59

These sample criteria are for screening patient care for subsequent physician review only and do not constitute standards of care.

September 1979

CHOLECYSTECTOMY, With or Without Exploration of Bile Ducts

III. POSTOPERATIVE COMPLICATIONS

A. See general comments on p. 15
B. Residual stone in the common duct
C. Biliary fistula and/or jaundice

IV. POSTOPERATIVE VALIDATION OF DIAGNOSIS

A. Surgeon's operative report
B. Verification of gallstones and/or acute cholecystitis by operative findings and/or pathology report

V. DISCHARGE STATUS

A. See general comments on p. 15

Developed By:
AMA General Surgery Criteria Committee
American Society of Internal Medicine
American College of Gastroenterology
American Gastroenterological Association

These sample criteria are for screening patient care for subsequent physician review only and do not constitute standards of care.

BRONCHITIS, CHRONIC, AND EMPHYSEMA	H-ICDA	ICDA-8	ICD-9-CM
	491, 492	491, 492	491, 492

I. UTILIZATION REVIEW

A. NEED FOR ADMISSION/PRESENTING SYMPTOMS/WORKING DIAGNOSIS

1. Suspicion or diagnosis of respiratory failure
2. Complicating cardiopulmonary conditions
3. Preparation of patient for elective surgery - (pulmonary prep)

B. INITIAL LOS/CONTINUED STAY

1. LOS - (Local option - LOS Checkpoint)
2. Extension information (Diagnosis specific or general)
    a. Persistent respiratory failure
    b. Cardiopulmonary complications (e.g., respiratory infection, pneumothorax, embolism, congestive heart failure)

II. VALIDATION OF:

A. SYMPTOMS, ENTERING (WORKING) DIAGNOSIS

1. Significant hypoxia or hypercapnea; or such symptoms as drowsiness, disturbed sensorium, cyanosis or coma
2. Persistence of dyspnea or cough and sputum
3. Respiratory infection, pneumothoras, embolism, congestive heart failure, trauma to chest
4. Presence of low arterial pO_2 requiring initiation of instruction in and monitoring of oxygen therapy
5. Scheduled for bronchoscopy

B. FINAL DIAGNOSIS (PRINCIPAL)

1. Radiologic evidence of emphysema or chronic bronchitis
2. Pulmonary function studies compatible with obstructive airways disease

Continued

These criteria are for screening patient care
for subsequent physician review only and
do not constitute standards of care.

BRONCHITIS, CHRONIC, AND
EMPHYSEMA - Continued

III. QUALITY REVIEW - CRITICAL DIAGNOSTIC AND THERAPEUTIC SERVICES

A.	Radiologic examination of the chest during this acute phase	Review if Absent
B.	Arterial blood gases during this acute phase	Review if Absent
C.	Electrolytes during the acute phase	REView if Absent
D.	One or more of the following during this acute phase: oxygen, aerosol therapy, bronchodilators, ventilators, chest physical therapy	Review if Absent
E.	Narcotics (except for purpose of pre-operative medication or in patients who are undergoing controlled ventilation)	Review if Present

IV. DISCHARGE PLANNING (INCLUDING LEVEL OF CARE / PATIENT INSTRUCTIONS)

V. INDICATIONS FOR DISCHARGE

These criteria are for screening patient care
for subsequent physician review only and
do not constitute standards of care.

PRO
REGULATIONS
SUMMARY AND STATUS

REGULATION SUMMARY

Utilization and Quality Control Peer Review Organization (PRO) Area Designation and Definitions of Eligible Organizations

Published February 27, 1984

Content of Final Rule

The PRO Act requires the Secretary to consolidate existing PSRO areas so that each State is generally designated as a statewide PRO area. Local or regional areas are allowed where the volume of review activity or other relevant factors warrant, and the Secretary determines that review activity can be carried out with equal or greater efficiency compared to statewide areas.

The final notice designated 54 PRO areas. Each State, the District of Columbia, the Virgin Islands and Puerto Rico would be separate areas. Guam, American Samoa, and the Trust Territory of the Pacific Islands would be combined into one PRO area.

The PRO Act requires that organizations, in order to be eligible to become PROs, must be either "physician-sponsored" or "physician-access." Physician-sponsored organizations must be composed of a "substantial" number of the licensed practicing physicians in the review area and be "representative" of such physicians. Physician-access organizations must have available to them a sufficient number of licensed practicing physicians in the review area.

Under the final rule, physician-sponsored organizations would meet the "substantial" numbers and representative tests if composed of at least 20 percent of the licensed physicians practicing in the PRO review area. If not composed of at least 20 percent of the area's licensed practicing physicians, a PRO must be composed of at least 10 percent of the physicians in the area and demonstrate, with additional documentation, that it is representative.

Physician-access organizations would meet the "availability" test by demonstrating that the number and types of physicians available to them is adequate to carry out the review plan which they propose.

The final rule requires that, at a minimum, the organization have available to it at least one specialist in every generally recognized speciality practiced in the area.

The statute and the final rule prohibit contracting with a health care facility or an association of facilities which provides services in the area that the PRO would review. The final rule also precludes contracting with an organization that is affiliated with, through management, ownership or control, a health care facility or association of facilities that provides services in the area in which the PRO would conduct review.

The final rule states that a State government operating a health care facility would be judged on a case-by-case basis as to whether it has a potential conflict of interest which would preclude it from becoming a PRO. Furthermore, because State governments operate Medicaid programs, they would normally be considered incapable of performing utilization and quality review activities in an effective manner, unless a State demonstrates to HCFA's satisfaction that it will act with complete independence and objectivity.

Status

Final regulation was published on February 27, 1984

Conduct of Review and Medicaid Relationships with PROs

Content of Regulation

This final rule outlines the relationship which will exist among PROs, fiscal intermediaries, providers, and beneficiaries when PROs assume responsibility for review. (Detailed PRO responsibilities, such as objectives and performance criteria, will be spelled out in the PRO contract. A description of the relationships between the PROs and HCFA, such as reporting and monitoring of contracts, will also be included in the contract.) The rule also outlines PRO utilization and quality review functions. There are several provisions in the rule that deserve special mention:

a. PROs may subcontract (delegate) only quality review to hospitals. Subcontracting to hospitals of any other review would present possible conflicts between a hospital's financial interests and the goals of PRO review. This would be counter to congressional intent to avoid such conflicts.

b. FIs will be responsible for making coverage determinations for all claims not reviewed by the PRO:

   (1) PROs review only those cases specified in their contracts with HCFA.

   (2) FIs make coverage determinations for all claims for reasons other than medical necessity, reasonableness, and appropriateness.

   FIs, however, will obtain and abide by a PRO's finding of medical necessity and reasonableness for certain items and services (not otherwise reviewed by the PRO) included in the Coverage Issues Appendix that must meet specific conditions of medical necessity and reasonableness to be covered.

   (3) PRO review and denial of claims will be consistent with Medicare rules on administrative finality of coverage decisions. Denials should generally be made within 12 months of the date of the claim containing the services in question. After 12 months and within 48 months, denial may be made only by showing good cause and gaining HCFA approval. If there is a finding of fraud or abuse, a PRO may at any time review and deny a claim or reopen a denial decision.

c. Services provided by a doctor of medicine, osteopathy, or dentistry, must be reviewed by a peer actively practicing his profession unless a PRO determines that peers are not available, in which case a doctor of medicine or osteopathy may make denial determinations for services ordered by a doctor in any of the three specialties.

d. PROs may deny claims from providers whose lack of cooperation prevents review from taking place: the financial liability of these claims would be assigned to the provider.

e. The rule sets forth the following responsibilities of health care facilities with regard to pre-admission review:

(1) Assuring that each case subject to preadmission review has been reviewed and approved by the PRO before admission, or a timely request has been made for PRO review.

(2) Agreeing to accept financial liability for any admission subject to preadmission review that was not reviewed by the PRO and is subsequently denied by the PRO.

This provision does not apply if a facility makes a timely request for preadmission review and the PRO does not review the case in a timely fashion. In this case, the PRO would conduct retrospective review.

(3) Agreeing that if the hospital admits a case subject to preadmission review without certification the case must receive retrospective prepayment review according to the review priority established by the PRO.

The rule also contains provisions governing Medicaid relationships with PROs:

a. States may, at their option, contract with PROs to perform review of Title XIX services: if they do so, the State may be eligible for 75 percent Federal Financial Participation (FFP) for the costs of such review.

b. The rule provides that State agencies may contract with PROs for performance of medical and utilization review functions and receive 75 percent FFP, as long as the review is not inconsistent with the review the PRO is conducting under Title XVIII.

UC requirements on plan of care and physician certification are not deemed met when a State contracts with a PRO. The law specifies that States may contract only for those services which are functions of the PRO (medical and utilization review). Therefore, those will be the only UC elements deemed met.

Status

The final regulation was published on April 17, 1985.

Reconsideration and Appeals

Content of the Regulation

The rule sets forth policies and procedures by which determinations of PROs will be subject to reconsideration and further appeals. The basic policy is that a beneficiary, practitioner, or provider dissatisfied with a PRO's initial adverse determination (i.e., denial) is entitled to a reconsideration by the PRO. The rule also, in accordance with specific statutory directives, specifies that the beneficiary will have further appeal rights including an administrative hearing before an Administrative Law Judge (ALJ) (where the reconsideration determination is adverse and the amount in controversy is at least $200), and the Appeals Council and judicial review where the amount in controversy is over $2,000.

In addition, the following provisions should be noted:

a. A beneficiary may submit a request for a reconsideration to the PRO or PRO subcontractor, an SSA District Office, or a Railroad Retirement Board. A provider or practitioner must submit a request for a reconsideration to the PRO or the PRO subcontractor.

b. The request for a reconsideration must be filed within 60 days after receipt of notice of an initial determination, unless there is good cause for late filing of the request. For a beneficiary who is still an inpatient or is awaiting admission, a request for an expedited reconsideration may be filed within 3 days of the notice.

c. Subject to rules on disclosure of information, a provider, practitioner, or beneficiary has a right to examine material upon which the initial determination was based.

d. A reconsideration reviewer must be a specialist in the type of services under review and must not be the same individual who made the initial denial determination.

e. A PRO must issue a reconsidered determination within 3 working days of an expedited reconsideration request, within 10 working days if the beneficiary is still a patient in an SNF, and within 30 working days for all other cases.

f. If, during the course of DRG validation, the PRO changes the diagnostic or procedural coding used on the claim and this results in a lower Medicare payment, the provider or practitioner may request a review. A beneficiary cannot obtain a review of a DRG assignment, and the provider and practitioner have no further appeal rights after the review. However, when assignment of a different DRG results in noncoverage of a furnished service, the beneficiary may appeal that determination.

g. The beneficiary must submit a request for a hearing within 60 days of receipt of the reconsideration notice.

Status

The final regulation was published on April 17, 1985.

Confidentiality

Content of the Regulation

The rule applies to all information obtained or developed by a PRO and sets forth rules governing protection and disclosure of information generated by a PRO and access to the information by others.

The general rules applying to disclosure of information are:

a. The PRO must notify a practitioner of its intent to disclose information at least 30 days before the intended disclosure.

b. A PRO must disclose public information in the form it is acquired by the PRO.

c. A PRO must provide reasonable physical security measures to prevent unauthorized access to PRO information.

d. A PRO must disclose nonconfidential information to any person upon request.

e. A PRO must disclose information about patients to the identified patient or representative, unless the information could harm the patient. A PRO must disclose information to institutions and practitioners about themselves.

f. A PRO must disclose information on practitioners and institutions to the Department of Health and Human Services, to the Office of the Inspector General, the General Accounting Office, fraud and abuse agencies, and to licensing and certification agencies.

g. A PRO must not disclose its deliberations except to HCFA, the General Accounting Office or the Office of the Inspector General.

h. A PRO may disclose to the public PRO interpretations and generalizations on the quality of health care in a particular institution.

Status

The final regulation was published on April 17, 1985.

Sanctions

Content of the Regulation

The rule defines the sanctions process under PROs and implements portions of the PRO statute that impose obligations (provision of care to beneficiaries which is medically necessary, appropriate, and of adequate quality) on health care practitioners and providers; requires PROs to report violations of such obligations to the Secretary; and, authorizes the Secretary to make decisions upon a PRO's recommendation to exclude from the Medicare program or impose a monetary penalty against practitioners or providers who have not met their obligations. Under the regulations, PROs are required to give notice to and opportunity for discussion with the affected practitioner or provider before making a final determination that the practitioner or provider has failed to comply substantially with an obligation in a substantial number of cases or grossly and flagrantly violated an obligation in one or more instances. The following provisions should be noted:

a. When a PRO determines that a substantial violation has occurred in a substantial number of cases or a violation is gross and flagrant, it must send a notice to the involved party delineating the violation and the proposed sanction and give the party a right to submit additional information within 30 days.

b. If the issue is not resolved, the PRO will submit its report and recommended sanction to the Office of the Inspector General.

c. In cases of recommended exclusion from Medicare, if the Secretary does not act within 120 days, the practitioner or provider being sanctioned would automatically be excluded from eligibility to provide services on a reimbursable basis until such time as the Secretary determines otherwise. Also, payment will not be made to any provider for services orderd by an excluded practitioner.

d. The Office of the Inspector General notifies the practitioner of the sanction, effective 15 days from the date of receipt of the notice.

e. In lieu of the sanction of exclusion, the Secretary may require monetary penalty (not to exceed the actual or estimated costs of the medically improper or unnecessary services provided) as a condition to the continued eligibility of the practitioner or provider to provide health care services on a reimbursable basis.

Status

The final regulation was published on April 17, 1985.

DEPARTMENT OF HEALTH AND HUMAN SERVICES

August 7, 1985

Mohammad Akhter, M.D.
Executive Vice President/Medical Director
Missouri Patient Care Review Foundation
1026 C Northeast Drive
Jefferson City, Missouri 65101

Dear Dr. Akhter:

This is in response to your letter of July 24, 1985, regarding two cases which appear to involve types of prohibited actions which circumvent PPS. The Health Standards and Quality Bureau recently issued new Interim Manual instructions, effective July 25, 1985, defining specific actions PROs may take when a hospital has circumvented PPS through unnecessary admissions, readmissions, or other inappropriate medical practices. We forwarded a copy of these instructions to you in a letter dated July 30, 1985, and recommend that they be used in handling the two cases you referred.

The first case involves a patient who was prematurely discharged from the Kansas University Medical Center, with a readmission to St. John's Regional Medical Center. In addition to substandard quality of care, this situation appears to fall under paragraph IM-2086B, which occurs "when a patient is readmitted to a hospital for care that, pursuant to professionally recognized standards of health care, could have been provided during the first admission." Intervention required under paragraph IM2088 in these circumstances would appear to include denial of the second admission. However, we asked HSQB to clarify whether a denial would be appropriate when the second admission is to a different hospital. The Health Standards and Quality Bureau indicated that paragraph 2086B applies only when the patient is readmitted to the same hospital. Therefore, you should proceed only with corrective action as defined under paragraph 2088-B.

The second case, in which a patient was admitted for an invasive cardiac catheterization and readmitted five days later for bypass surgery appears to fall under paragraph IM-2086A. Paragraph IM-2088A requires that the second admission be denied in those situations.

I hope this guidance is helpful to you in handling these cases, as well as similar instances of premature discharge and substandard quality which may arise in the future.

Sincerely yours,

Gregory A. Lear, Chief
Medical Review Branch
Division of Health Standards and Quality

FILE
COPY

OFFICE	SURNAME	DATE	OFFICE	SURNAME	DATE	OFFICE	SURNAME	DATE
MRB	Lear	8/7/85						

HSQ/MRB:BURTON:lm

Medicare

Peer Review Organization Manual

Department of Health
and Human Services
Financing
in

[This copy of Transmittal No. 5 replaces
HCFA Transmittal No. IM 85-2, and was
sent to the Committee on August 8, 1985
with the annotation "Advance Copy of
Final Issuance".]

ransmittal No. 5

Date AUGUST 1985

REVISED MATERIAL	REVISED PAGE NOS.	REPLACED PAGES
Title Page, Part 3	(1p.)	—
Table of Contents Part 3	3-1 (1p.)	—
Sections 3000-3025	3-5 - 3-9 (5 pp.)	—

NEW PROCEDURES - EFFECTIVE DATE: JULY 25, 1985

Section 1886(f)(2) of the Social Security Act provides specific actions which may be taken when a hospital circumvents the Prospective Payment System (PPS) through unnecessary admissions, readmissions, and other inappropriate medical practices. This issuance defines those practices and outlines corrective action when the PRO determines that such practices have occurred. The corrective actions include denials, sanctions, intensified review, referrals to ROs, and/or referrals to OIG. There are some mitigating circumstances that will be detailed in a future issuance.

Section 3000, Purpose of Readmission and Transfer Review.—This section defines the authority for actions that may be taken when a hospital circumvents the Prospective Payment System and describes provider appeal rights in the case of PRO denials.

Section 3005, PRO Review Responsibilities.—This section requires PROs to review readmission and transfer cases as described in their contracts.

Section 3010, Types of Prohibited Actions Which Circumvent The PPS.—This section describes those actions a hospital might take which are considered to be circumventing the PPS.

Section 3015, Actions That Must be Taken by The PRO.—This describes those actions a PRO must take when it determines prohibited actions have occurred, including denials, sanctions, intensified review, referrals to the regional office, and referrals to OIG.

Section 3020, Handling Problem Cases.—This section requires PROs to report to the regional office those cases which are problems but do not fit into any of the categories listed in section 3010.

Section 3025, PRO Reporting Requirements.—This section requires PROs to describe in the Monthly Medical Review Report all activities to remedy prohibited actions, and gives the format for the report.

Workload and Costs

These instructions represents a slight increase in effort because PROs will now have to review both the initial and subsequent admissions in any case where a transfer occurs. It should not, however, represent a cost above that of the current fixed-price contracts.

PART THREE

UNNECESSARY READMISSIONS AND TRANSFERS

Part 3

Unnecessary Readmissions and Transfers

	Section	Page
Purpose of Readmission and Transfer Review....................	3000	3-5
PRO Review Responsibilities..................................	3005	3-5
Types of Prohibited Actions Which Circumvent the PPS.........	3010	3-5
Actions That Must be Taken by The PRO........................	3015	3-6
Handling Problem Cases.......................................	3020	3-7
PRO Reporting Requirements...................................	3025	3-8

Unnecessary Readmissions and Transfers

3000. PURPOSE OF READMISSION AND TRANSFER REVIEW

Section 1886(f)(2) of the Act provides specific actions that may be taken when a hospital has circumvented the Prospective Payment System through unnecessary admissions, readmissions, and other inappropriate medical practices. If a hospital's actions result in unnecessary admission or readmission, its payment may be denied. If the hospital's actions result in other inappropriate medical or other practices, other corrective action may be taken.

Actions taken pursuant to Section 1886(f)(2) of the Act and the regulations at 42 CFR 466.70(c)(8) and (d) are in addition to the medical necessity, quality, and level of care determinations made by a PRO under Section 1154 of the Act. Because the denial actions specified in this part are made pursuant to Section 1886(f)(2), providers are generally entitled to a hearing and judicial review of the denial determination. (Section 1862(d) and 1866(f)(3).) This is in contrast to the more limited appeal rights available under Section 1155 and 42 CFR Part 473 to providers seeking review of other PRO determinations.

These determinations are not made under Sections 1154, 1862(a)(1) or (a)(9). Therefore, the waiver of liability provisions of section 1879 are not applicable and the provider will be liable. The beneficiary will not be charged for services denied under these instructions.

3005. PRO REVIEW RESPONSIBILITIES

Select readmission and transfer cases for review as described in your contract with DHHS. Review the medical record for both the initial admission and the readmission or transfer.

3010. TYPES OF PROHIBITED ACTIONS WHICH CIRCUMVENT THE PPS

When the hospital takes any of the following actions it is presumed that the hospital intended to circumvent the PPS System

A. Premature Discharge of a Patient That Results in The Subsequent Readmission of The Patient to The Same Hospital.—A premature discharge of a patient occurs when a patient is discharged even though he should have remained in the hospital for further testing or treatment, or was not medically stable at the time of discharge. A patient is not medically stable when, in the judgement of the PRO, the patient's condition is such that it is medically unsound to discharge or transfer the patient. Evidence such as elevated temperature, postoperative wound draining or bleeding, or abnormal laboratory studies on the day of discharge indicate that a patient may have been prematurely discharged from the hospital.

B. Readmission of a Patient to a Hospital for Care That Could Have Been Provided During The First Admission.--This prohibited action occurs when a patient is readmitted to a hospital for care that, pursuant to professionally recognized standards of health care, could have been provided during the first admission. This action does not include circumstances in which it is not medically appropriate to provide the care during the first admission.

C. Inappropriate Transfer of a Patient From a PPS Unit to a PPS-Exempt Unit in The Same Hospital.--A transfer is considered an admission for purposes of payment under PPS (42 CFR 405.470). A prohibited action occurs when a patient is admitted to an acute care part of the hospital even though the medical record shows that patient required care in a PPS-exempt psychiatric or rehabilitation unit within the same hospital, a bed in the PPS-exempt unit was available at the time of initial admission, and the patient is subsequently transferred to the PPS-exempt unit. This also applies to similar transfers from PPS units to beds in hospital-based SNFs and swing beds.

D. Transfer of a Patient From a PPS-Exempt Unit to a PPS Unit in The Same Hospital.--A prohibited action occurs when a patient who requires only the level of care being provided him in the PPS-exempt unit is transferred to a PPS unit in the same hospital. A prohibited action also occurs when the transfer is from a PPS-exempt unit to a hospital-based SNF or swing bed.

3015. ACTIONS THAT MUST BE TAKEN BY THE PRO

A. Denials.--When any of the actions prohibited in section 3010 occur, deny the second admission.

B. Other Actions.--In addition to denials for prohibited actions you must institute one of the following corrective actions when you identify substandard quality of care. Quality of care is always substandard when a readmission results because the patient was not medically stable when discharged. Quality of care is always substandard when a transfer is made before the patient is medically stable except when the transfer is necessitated because the patient needs more intensive or specialized services. Care may be substandard in other situations, such as where an inappropriate readmission or transfer causes or contributes to a worsening of the patient's medical condition.

1. Sanctions.--Initiate a sanction report and recommendation:

a. If the prohibited action causes a patient's death, presents an imminent damage to the health, safety or well-being of a Medicare beneficiary, places the beneficiary unnecessarily in high-risk situations, or results in permanent loss of a major physical function, immediately develop a sanction recommendation, based on a "gross and flagrant" violation of the responsible provider's or physician's Medicare obligations.

b. If a provider or practitioner is responsible for two episodes involving prohibited actions in a single quarter, you may initiate a sanction. If three or more instances (a "substantial number of cases") occur in a quarter, you must develop a sanction recommendation.

2. Intensified Review.—Intensify review of the responsible physician or hospital by reviewing 100 percent of discharges, not just those discharges related to the prohibited action.

3. Referrals to Regional Office.—If you initiate a sanction report against two or more physicians practicing in the same hospital, or against the hospital itself, notify the regional office, Division of Health Standards and Quality, and provide supporting information. This action is taken so that the regional office can investigate whether the hospital is in compliance with the Conditions of Participation (i.e., 42 CFR 405.1023, Conditions of Participation-Medical Staff).

4. Referrals to Office of The Inspector General.—

a. When you identify a hospital that has a pattern of prohibited action, refer the cases included in the pattern to the regional Office of the Inspector General for potential termination of the provider agreement under section 1866(b) of the Act and 42 CFR 504.472(e)(3).

b. If you suspect that fraud or an abusive practice is involved, refer individual cases to the regional Office of the Inspector General for further investigation. Examples of such practices include a hospital submitting two separate claims for a given patient, as if the patient were readmitted to the hospital but you find that the patient was discharged only once from the hospital, or you identify two hospitals as having an unexplained pattern of Medicare transfers between them.

3020. HANDLING PROBLEM CASES

In cases involving Medicare readmissions and transfers which are problems but do not clearly fit into any of the categories described above, assume the readmission or transfer is appropriate. However, also refer the case with a brief summary of the issues to the Regional Office, Division of Health Standards and Quality.

3025. PRO REPORTING REQUIREMENTS

Describe in the Monthly Medical Review Report submitted to the Division of Program Operations, HSQB, all activities to remedy prohibited actions using the following format:

A. Number of Denials

1. Premature discharge of a patient that results in a subsequent readmission to the same hospital (3010A).__________________

2. Readmission of a patient to a hospital for care that could have been provided during the first admission (3010B).__________________

3. Inappropriate transfer of a patient from a PPS unit to a PPS-exempt unit in the same hospital or to beds in a hospital-based SNF or swing bed in the same hospital (3010C).__________________

4. Inappropriate transfer of a patient from a PPS-exempt unit to a PPS unit in the same hospital where the patient only required care in the exempt unit (3010D).__________________

B. Other Actions

1. Sanctions

3010A __________________
3010B __________________
3010C __________________
3010D __________________

TOTAL

2. Intensified Review

3010A __________________
3010B __________________
3010C __________________
3010D __________________

TOTAL

3. Referrals to RO

3010A ________________
3010B ________________
3010C ________________
3010D ________________

TOTAL

4. Referrals to OIG

3010A ________________
3010B ________________
3010C ________________
3010D ________________

TOTAL

Reporting Date: 8 / 9 / 85

NDHCRI INCIDENCE REPORT TO REGIONAL OFFICE

Patient Name: ________ ________ HIC NO.: __________ Age: 87

Admit Date: 3 / 7 / 85 Hosp. Name __________ MPR No. 35- _____

Physician Name: ___ _ ________ M.D. License No.: __________

Reviewer Numbers: R.S. [redacted] P.A. [redacted] Reviewed: 8 / 5 / 85

Incidence Type:

___A. Readmission Subsequent to a Pre-mature Discharge
_X_B. Transfer Of a Questionable Nature
___C. Hospital Initiated Denial Not Reported on Monthly List
___D. Inappropriate Hosp. Init. Den. Issued Prior to DRG ALOS

(Narrative description of the problem or discrepancy using as accurate direct language as possible. Use physicians orders and physician advisor notes for quotations where possible.)

This case involves an 87 year old female who was admitted to the [redacted] on 2/27/85 for treatment of bronchopneumonia. The patient was transferred to a swing bed on 3/7/85. The case was referred to a Physician Advisor as a questionable transfer. The Physician Advisor's comments follow: "Appears to be an inappropriate level of care. The patient had an acute pneumonia on x-ray at the time the patient was transferred from acute care to swing bed. I believe the patient should have been in acute care until cured and then discharged home".

Distribution - Type	A	B	C	D
NDHCRI	A	B	C	D
Regional Office	A	B	C	D
Hospital	A	B	C	D
Attending Physician	A	B	C	D
Fiscal Intermediary				D
Patient				D

MISSOURI
PATIENT CARE REVIEW
FOUNDATION

1026 C Northeast Drive • Jefferson City, Missouri 65101 • (314) 634-4441

Mohammad N. Akhter, M.D.
Executive Vice President
and Medical Director

Thomas E. Mangus
Director of Operations

August 9, 1985

Mr. Greg Lear, Chief
Medical Review Branch
601 East 12th Street
Kansas City, Missouri 64111

Re: Contract No. 500-84-0526-93
MO 007

Dear Mr. Lear:

I am responding to your letter of August 2, 1985 regarding IM 85-2, section IM 2060.2 which indicates the FI is suppose to screen claims for statutory exclusions and refer those needing medical necessity decisions to the PRO for review. This is to advise you it is our intent to request additional funding under a modification of the contract if this requirement necessitates above and beyond the fixed price contract in effect. This will be in addition to those other areas identified which require additional resources to implement IM 85-2.

Sincerely,

Thomas E Mangus

Thomas E. Mangus
Director of Operations

TEM:bjs

cc: Mohammad N. Akhter, M.D.
Mr. William Tate

BB

THE KANSAS FOUNDATION FOR MEDICAL CARE INC.
2953 S.W. Wanamaker Drive / Topeka, Kansas 66614
Telephone: (913) 273-2552

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Kansas City

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Executive Director
Larry W. Pitman
Topeka

Medical Director
G. Rex Stone, M.D.
Manhattan

August 12, 1985

Mr. Bill Tate
Chief, Contract Branch
Health Care Financing Administration
6325 Security Boulevard
East Highrise Building Room 322
Baltimore, Maryland 21207

Dear Mr. Tate:

This letter constitutes a formal request for a modification of our PRO contract as a result of the implementation of IM 85-2. The following is a breakdown of the additional costs to KFMC above the original fixed price contract:

1.	Printing and mailing expense for revised review plan.	$2,000.00
2.	Copying and mailing of the revised procedure for notification of attending Physicians of potential denials.	500.00
3.	Additional Physician Reviewer expense required by the revised procedure for notifying attending Physicians of potential denials (780 hours Xs $54.00).	42,120.00
4.	Three additional FTE's are required. a) One (1) FTE to coordinate the new procedure for the potential denial protocol. 8/14/85 [illegible] b) One (1) clerical FTE to schedule reconsiderations. The new regulations re-established a 30 day turn-around time for reconsiderations requested by the hospital/attending. In order to meet this more restrictive time frame, additional staff is needed. c) One (1) FTE for an additional Area Review Coordinator. This new position is needed to absorb the additional review responsibilities contained in 85-2. These include: Calculation of quarterly denial rates for outliers. Requirement to notify hospital of preadmission results.	64,000.00

Reviewing for third-party liability.
Reopening previously denied cases if new information is provided.
Requirement to determine if medical necessity exists anytime during a hospital stay.
Requirement that we review for coverage issues.
Increased review responsibilities in the area of attestation statements and penalty statements.
Review of DRG 462.
Review of hospital requested claim adjustments.

5. Additional telephone expense generated by the requirement to permit attending Physicians the opportunity to discuss potential denials 6,000.00

6. Additional office space required for the handling of additional information resulting from the notification to attending Physicians regarding potential denials 2,000.00

7. Programming changes in Medicare software generated by the implementation of 85-2 17,300.00

Therefore, it is requested that our contract be amended to include additional reimbursement in the amount of $133,920.00.

Sincerely yours,

Larry W. Pitman
Executive Director

LWP/GZ/de

xc: Ms. Brenda Burton, PRC Project Officer
Kansas City, Missouri
Ms. Elizabeth Faykus, Contract Specialist
HCFA, Baltimore, Maryland

1040B-9/10

Colette

QUALITY
UTILIZATION
APPROPRIATENESS
AQAF
STATE
PEER REVIEW
ORGANIZATION

ALABAMA QUALITY ASSURANCE FOUNDATION
SUITE 300, TWIN TOWERS EAST
236 GOODWIN CREST DRIVE
BIRMINGHAM, ALABAMA 35209
TELEPHONE (205) 942-0785

GENERAL MEMORANDUM #85-19

MEMO: ADMINISTRATORS AND CHIEFS OF STAFF, ALL ALABAMA HOSPITALS

INFO: TOMMY MCDOUGAL/ALAHA; ED FARRELL/BRHC; MARY GREGORY/DHHS; AQAF BOARD OF DIRECTORS

FROM: JOHN W. MILLER, CHIEF EXECUTIVE OFFICER

DATE: AUGUST 15, 1985

SUBJ: PROHIBITED ACTIONS WHICH CIRCUMVENT THE PPS.

ALABAMA QUALITY ASSURANCE FOUNDATION, INC.

I. Enclosed is a copy of Section 2082-2092 to the PRO Manual - Interim Manual Instructions. Please note the change is effective July 25, 1985 discharges.

II. Please review Section IM 2086 which defines "Prohibited Actions".

III. Please note that Section IM 2088 requires the PRO to deny the second admission when any "Prohibited Action" occurs. While the Foundation does not agree with this action, as you can see, the Foundation is left no choice.

IV. To date, the Foundation has been using educational letters as corrective action to "Prohibited Actions". There have not been large numbers of these actions to date in Alabama as the pre-admission/transfer review system tends to eliminate these "actions". Your continued cooperation will be appreciated.

Enclosure
:agw

DEPARTMENT OF HEALTH & HUMAN SERVICES

Health Care Financing
Administration

Region IV
101 Marietta Tower
Atlanta GA 30323

RECEIVED
AUG 02 1985
Ans'd............

July 29, 1985

ATLANTA REGIONAL MEDICAL REVIEW LETTER NO. 12-85
(Of Interest to Peer Review Organizations)

SUBJECT: PRO MANUAL - INTERIM MANUAL INSTRUCTIONS

Enclosed are interim manual instructions outlining corrective actions to be taken when a PRO determines that a hospital has circumvented the prospective payment system through unnecessary admissions, readmissions, or other inappropriate medical practices. The corrective actions include denials, sanctions, intensified review, referrals to ROs, and referrals to OIG.

George R. Holland

George R. Holland
Regional Administrator
Health Care Financing Administration
Region IV

Attachment

PRO MANUAL

INTERIM MANUAL INSTRUCTIONS

NEW PROCEDURES - EFFECTIVE DATE: July 25, 1985

Section 1886(f)(2) of the Social Security Act provides specific actions which may be taken when a hospital circumvents the prospective payment system (PPS) through unnecessary admissions, readmissions, and other inappropriate medical practices. This transmittal defines those practices and outlines corrective action to be taken when the PRO determines that such practices have occurred. The corrective actions include denials, sanctions, intensified review, referrals to ROs, and/or referrals to OIG. There are some mitigating circumstances that will be detailed in aa future issuance.

REVISION

Section 2082-2092 are all new requirements.

Workload and Costs

The attached transmittal represents a slight increase in effort because PROs will now have to review both the initial and subsequent admissions in any case where a transfer occurs. It should not, however, represent a cost above that of the current fixed-priced contracts.

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Interventions that Must be Undertaken by the PRO.......... 2088

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IM 2082. Purpose of Review.

The purpose of this transmittal is to further clarify and implement Section 1886(f)(2) of the Social Security Act (Act) and regulations at 42 CFR 466.70(c)(8) and (d). Section 1886(f)(2) provides specific actions that may be taken when a hospital has circumvented the prospective payment system through unnecessary admissions, readmissions, or other inappropriate medical practices. If a hospital's actions result in an unnecessary admission or readmission, its payment may be denied. If the hospital's actions result in some other inappropriate medical or other practice, then other corrective action may be undertaken.*

Actions taken pursuant to Section 1886(f)(2) and the regulations at 42 CFR 466.70(c)(8) and (d) are in addition to the medical necessity, quality, and level of care determinations made a PRO under Section 1154 of the Act. Because the denial actions described below are made pursuant to Section 1886(f)(2), providers are, under certain circumstances, entitled to a hearing and judicial review of the denial determination. (Sections 1862(d) and 1866(f)(3) of the Act and regulations at 42 CFR part 405, part 0). This is in contrast to the more limited appeal rights available under Section 1155 and 42 CFR Part 473 to providers seeking review of other PRO determinations.*

IM 2084 PRO Responsibilities for Review

PROs are to select readmission and transfer cases for review as described in their contracts. However, prior to this transmittal, PROs were given the option to review the medical record of the initial admission of any transfer case. PROs are now required to review both the initial admission and the transfer.

→ IM 2086 Descriptions of Prohibited Actions Which Circumvent the PPS

When the hospital takes any of the following actions it is presumed that the hospital intended to circumvent the PPS System.

A. Premature Discharge of a Patient That Results in the Subsequent Readmission of the Patient to the Same Hospital.--A premature discharge of a patient occurs when a patient is discharged even though he should have remained in the hospital for further testing or treatment, or was not medically stable at the time of discharge. A patient is not medically stable when, in the judgment of the PRO, the patient's condition is such that it is medically unsound to discharge or transfer the patient. Evidence showing such a situation (such as elevated temperature, postoperative wound draining or bleeding, or abnormal laboratory studies on the day of discharge) indicates that a patient may have been prematurely discharged from the hospital.

---

*These determinations are not made under Section 1154, 1862(a)(1) or (a)(9). The waiver of liability provisions of section 1879 are therefore not applicable -- the provider will be liable. The beneficiary will not be charged for services denied under these instructions.

B. Readmission of a Patient to a Hospital for Care That Could Have Been Provided During the First Admission--.This prohibited action occurs when a patient is readmitted to a hospital for care that, pursuant to professionally recognized standards of health care, could have been provided during the first admission. This action does not include circumstances in which it is not medically appropriate to provide the care during the first admission.

C. Inappropriate Transfer of a Patient From a PPS Unit to a PPS-Exempt Unit in the Same Hospital--.This prohibited action occurs when the following events take place:

(1) A patient is admitted to a PPS unit of a hospital even though the medical record shows that the patient only required care in a PPS-exempt psychiatric or rehabilitation unit within the same hospital;

(2) A bed was available in the PPS-exempt unit at the time the patient was admitted; and,

(3) The patient is subsequently transferred to the PPS-exempt unit.

This prohibited action also applies to similar transfers from PPS units to beds in hospital-based SNFs and swing beds.

D. Inappropriate Transfer of a Patient From a PPS-Exempt Unit to a PPS Unit in the Same Hospital--.This prohibited action occurs when a patient who requires only the level of care being provided him in the PPS-exempt unit is transferred to a PPS unit in the same hospital. This prohibited action also occurs when the transfer is from a PPS-exempt unit to a hospital-based SNF or swing bed.

→ IM 2088. Interventions that Must be Undertaken by the PRO

A. Denials.--When any of the prohibited actions described above occur, deny the second admission.

B. Other Actions.--In addition to denials for prohibited actions you must institute one of the following corrective actions when you identify substandard quality of care**.

---

*A transfer is considered an admission for purposes of payment under PPS (42 CFR 405.470(c))

**Quality of care is always substandard when a readmission or a transfer results because the patient was not "medically stable" when discharged. Care may be substandard in other situations, such as where an inappropriate readmission or transfer causes or contributes to a worsening of the patient's medical condition.

1. Sanctions.--Initiate a sanction report and recommendation as follows:

   - o If the prohibited action causes a patient's death, presents an imminent damage to the health, safety, or well-being of a Medicare beneficiary, places the beneficiary unnecessarily in high-risk situations, or results in permanent loss of a major physical function, immediately develop a sanction recommendation, based on a "gross and flagrant" violation of the responsible provider's or physician's Medicare obligations.

   - o In other cases, if a provider or practitioner is responsible for two episodes involving prohibited actions in a single quarter, you may initiate a sanction. If three or more instances (a "substantial number of cases") occur in a quarter, you must develop a sanction recommendation.

2. Intensified Review.--Intensify review of the responsible physician or hospital by reviewing 100 percent of discharges, not just those discharges related to the prohibited action.

3. Referrals to Regional Office.--If you initiate a sanction report against two or more physicians practicing in the same hospital, or against the hospital itself, notify the regional office, Division of Health Standards and Quality, and provide supporting information. This action is to be taken so that the regional office can investigate whether the hospital is in compliance with a Condition of Participation (i.e., 42 CFR 405.1023, Condition of Participation-Medical Staff).

4. Referrals to Office of the Inspector General.--

   - o Where you identify a hospital that has a pattern of prohibited action, refer the cases included in the pattern to the regional Office of the Inspector General for potential termination of the provider under section 1866(b) of the Act and 42 CFR 504.472(e)(3).

   - o In some instances, you may suspect that fraud or an abusive practice is involved. For example, a hospital may submit two separate claims for a given patient, as if the patient were readmitted to the hospital. However, you may find that the patient was discharged only once from the hospital. Also, you may identify two hospitals as having an unexplained pattern of Medicare transfers between them. In such instances, refer individual cases to the regional Office of the Inspector General for further investigation.

IM 2090 Problematical Cases

There will be cases involving Medicare readmissions and transfers which are problems but do not clearly fit into any of the categories described above. In such cases, assume the readmission or transfer is appropriate. However, also refer the case with a brief summary of the issues to the regional office, Division of Health Standards and Quality. These summaries will be used to consider revisions of these instructions.

IM 2092 Reporting Requirements

You are to document in the Monthly Medical review report submitted to the Divison of Program Operations, HSQB, all activities to remedy prohibited actions in the following format:

A. Denials.--

1. Premature discharge of a patient that results in a subsequent readmission (2086A). to same hospital____________

2. Readmission of a patient to a hospital for care that could have been provided during the first admission (2086B)__________

3. Inappropriate transfer of a patient from a PPS unit to a PPS-exempt unit in the same hospital, or to beds in hospital-based SNFs or swing beds (2086C)

4. Transfer of a patient from a PPS unit in the same hospital where the patient only required care in the exempt unit (2086D)______________

B. Other Actions.--

1. Sanctions

2086A ________
2086B ________
2086C ________
2086D ________

TOTAL ________

2. Intensified Review

2086A ________
2086B ________
2086C ________
2086D ________

TOTAL ________

3. Referrals to RO

2086A ______
2086B ______
2086C ______
2086D ______

TOTAL ______

4. Referalls to OIG

2086A ______
2086B ______
2086C ______
2086D ______

TOTAL ______

Health Care Review Inc.

The Weld Building
345 Blackstone Boulevard
Providence, Rhode Island 02906
Tel. (401) 331-6661

Edward J. Lynch
Executive Vice President

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Maine Representative (Ex-Officio)

*Member, Executive Committee

August 15, 1985

Ms. Annette Kasabian
Chief, Office of Medical Review
Health Care Financing Administration
Health Standards & Quality Bureau
John F. Kennedy Federal Building
Government Center
Boston, MA 02203

Dear Annette:

In regard to my letter of August 8th pertaining to a relationship between Health Care Review Inc. and the Rhode Island Medical Society regarding peer review activities, I submit to you a letter from Doctor Rakatansky to Doctor Crisafulli regarding our meeting.

With best wishes, I am

Sincerely yours,

Edward J. Lynch
Executive Vice President

EJL:mas
Enclosure
cc: Frederick S. Crisafulli, M.D., President

371 Fore Street
Rinaldi Building
Suite 201
Portland, Maine 04101
Tel. (207) 879-0544

Wing Park Estates
412 State Street
Bangor, Maine 04401
Tel. (207) 945-0244

Rhode Island Medical Society
106 Francis Street, Providence, Rhode Island 02903 (401) 331-3207

August 8, 1985

AUG 1 4 1985

Frederick Crisafulli, M.D.
Health Care Review Inc.
345 Blackstone Blvd.
Providence, R.I. 02906

Dear Fred:

I'd like to thank you very much for your hospitality on Wednesday. I enjoyed talking to you and Mr. Lynch about the operation of Health Care Review. As you know, the Rhode Island Medical Society is sponsoring two peer review committees which may be of help in improving the quality and standard of care in Rhode Island. The Impaired Physician's Committee deals exclusively with doctors who are afflicted by illnesses. Most of our work is with psychiatric disturbance or chemical dependence. The Committee has had a significant experience in this area and has a protocol which seems to work quite well at this time. We would encourage any transfer of information which would benefit the individual physician and by virtue of treating him or her raise the quality of care, decrease over or under utilization and generally improve the practice situation in Rhode Island.

The second Committee is the Peer Review Committee on competency and this Committee deals through peer pressure with physicians, who in the absence of illness or criminal activity, practice outside the accepted standards of care. Remedial education is encouraged and utilization and quality of care can be maximized. Both of these Committees function as [illegible] official Peer Review Committees of the Rhode Island Medical Society. In the event that a physician is a threat to the public health and refuses the help of the Committee, the Board of Review is informed. No cover up is ever condoned.

I hope that it will be possible for Health Review to cooperate in this venture as it is certain that you will run across information which will be helpful to the rehabilitation of physicians during your reviews. I'll be happy to discuss in detail with you any of these programs or to elaborate if needed. Thank you very much for your anticipated cooperation.

Sincerely,

HERBERT RAKATANSKY, M.D.
PRESIDENT

Officers
Herbert Rakatansky, MD, *President*
Milton W. Hamolsky, MD, *Secretary*
[illegible]
[illegible]

Reporting Date: 8 / 19 / 85

NDHCRI INCIDENCE REPORT TO REGIONAL OFFICE

Patient Name:____________________ HIC NO.:__________ Age: 74

Admit Date: 5 / 5 / 85 Hosp. Name____________ MPR No.35-_____

Physician Name:_______________ M.D. License No.:__________

Reviewer Numbers: R.S. [redacted] P.A. [redacted] Reviewed: 8 / 12 / 85

Incidence Type:

X A. Readmission Subsequent to a Pre-mature Discharge
___B. Transfer Of a Questionable Nature
___C. Hospital Initiated Denial Not Reported on Monthly List
___D. Inappropriate Hosp. Init. Den. Issued Prior to DRG ALOS

(Narrative description of the problem or discrepancy using as accurate direct language as possible. Use physicians orders and physician advisor notes for quotations where possible.)

A 74 year old female was admitted to Hospital on 4/28/85 and discharged on 5/4/85. The patient was readmitted one day later with the same symptoms - abdominal discomfort and nausea. PA comments: "It appears from the documentation in the medical record that the patient's problem was not diagnosed or treated on either admission. Also, the documentation shows that the patient's weight increased over these admissions and an x-ray showed findings of bilateral basilar effusions due to cardiac decompensation which was not on the 4/27/85 x-ray. This is a readmission subsequent to a premature discharge."

Distribution - Type	A B C D
NDHCRI	A B C D
Regional Office	A B C D
Hospital	A B C D
Attending Physician	A B C D
Fiscal Intermediary	D
Patient	D

HCFA/HSQ Received AUG 22 '85

Health Care Review Inc.

The Weld Building
345 Blackstone Boulevard
Providence, Rhode Island 02906
Tel. (401) 331-6661

Edward J Lynch
Executive Vice President

August 20, 1985

Annette Kasabian
PRO Director
Health Standards & Quality Bureau
Health Care Financing Administration
John F. Kennedy Federal Building
Government Center
Boston, MA 02203

Dear Ms. Kasabian:

In recent weeks, we have discussed the Prospective Payment System, medical review, and quality review. In fact, there was a recent informal telephone poll taken by HCFA regarding quality problems identified under the Prospective Payment System and strong actions taken by the PRO.

INTRODUCTION

Regarding the issue of quality in the Prospective Payment System, in our judgement based upon our experience, a case-by-case quality review is absolutely a necessary integral part of the medical review function of a Professional Review Organization (PRO). Even though quality review is not a current integral part of the Prospective Payment System in the manner that utilization is on a case-by-case review, what is emerging in the nation seems to indicate a case-by-case review to identify and to resolve quality problems.

Health Care Review Inc. has had an internal staff debate from those who claim that we should adhere to what is specifically (literally) required in the contract to assure consideration of contract renewal. This argument has a great deal of legitimacy and a great deal of attractiveness for a program administrator concerned about balancing program need and performance with budget considerations.

An over-riding concern is whether there exists the delivery of good quality care in an economical manner to Medicare beneficiaries. As the program develops people will easily see through any attempt to emphasize cost at the expense of quality--especially when such problems are affecting the quality of care delivered to the elderly.

Annette Kasabian
Page Two
August 20, 1985

We are particularly concerned about the issue of quality because it goes to the heart of working with a fixed price contract, money versus workload, and one's ability to carry out what should be done for contractual purposes, but should be additionally addressed because it is in the interest of people.

Over the last several months, our physicians and staff, both in Rhode Island and in Maine, have been wrestling with the problem of how to deal with quality problems identified on a case-by-case basis; yet, we do not have the funding to deal with such quality problem.

The quality study objectives have been addressed through contractual funding with HCFA; yet, some claim that the objectives are not worth the time or effort of the medical profession because they may not be focusing on serious problem areas or areas in which a PRO can achieve real impact on the delivery system.

SPECIFIC QUALITY PROBLEMS IDENTIFIED IN RHODE ISLAND AND IN MAINE

Health Care Review Inc. staff has developed a list of quality problems identified in Rhode Island and in Maine (attached). We have also enumerated actions taken by our organization regarding those identified problems. Some of this information in Rhode Island had already been forwarded to the Regional Office, HSQB, by telephone to HCFA's informal protocol. We are also adding to this list quality problems identified in Maine, but no actions have yet been taken because of the developing nature of the issue and lack of staff.

We hope, in September, to submit to the Board of Directors a protocol for resolving such problems, but a serious question has been raised as to the practicality of having the Board consider a protocol when there are no financial resources to implement it.

We, therefore, are submitting to you the results of a draft protocol developed by the Health Care Review Inc. staff (see attachment pertaining to above cases).

The information contained in this letter provides sufficient information that should be considered on a case-by-case basis. We would welcome your response.

With best wishes, I am

Sincerely yours,

Edward J Lynch

Edward J. Lynch
Executive Vice President

EJL:mlc

ATTACHMENT

RHODE ISLAND

The following is a list of quality problems identified by Health Care Review Inc. and the actions taken to date:

Identified-Quality Problems	Action Taken
1. Patient admitted to hospital 023 in apparent shock-no action taken for several hours. Patient subsequently died.	Letters sent on 7/11/85 to attending physician and hospital administrator identifying a potentially serious quality issue. No response to date.
2. Patient admitted to hospital 017. From documentation in patient's record, there is lack of correlation between asystole on the rhythm strip and occurrence of death.	Letter sent on 7/18/85 to attending physician; no response to date.
3. Hospital 016 patient admitted with COPD, heavily medicated with Haldol and Ativan. Patient sustained a respiratory arrest and subsequently died after apparent inadequate monitoring of her respiratory status.	Case reviewed by three medical physicians, letters sent on 7/11/85 to attending Chief Executive Officer and Chief of service at hospital. Medical record and reviewers' comments forwarded to RO, HCFA consultant, for his comments regarding possible sanction. Response from Doctor in telephone call to of Health Care Review Inc. on 7/30/85. Case will be treated as educational need to hospital in writing.
4. Patient discharged prematurely from hospital 011 from apparent pressure exerted on physician by utilization nurses at that hospital.	Letters sent on 7/12/85 to attending physician, Chief Executive Officer, and Chief of Medical Staff. No response to date.
5. Patient discharged from hospital 026 to a nursing home facility not thought to be licensed as skilled at time of patient's discharge. Patient required skilled care due to G-tube insertion.	Letters sent on 7/19/85 to attending physician, CEO, and Chief of medical staff. Written response received from physician expressing concern about the matter and a telephone communication from the hospital stating that the facility was indeed licensed as skilled. Further investigation with indicated that facility was, indeed, licensed at time of patient's discharge.

Identified-Quality Problems	Action Taken
6. Medical record at hospital 011 showed incomplete work-up for evaluation of patient's back pain.	Letter sent on 7/12/85 to attending physician. Response received on 7/25/85 with explanation which seems to justify physician's course of action, although documentation of such in chart was absent.
7. Patient admitted to hospital 017. Work-up appeared incomplete as to etiology of CHF and decreased H/H.	Letter sent on 7/12/85 to attending physician. No response to date.
8. Work-up incomplete for patient admitted to hospital 020 with complaint of dizziness.	Letter sent on 7/12/85 to attending physician. No response to date.
9. Patient admitted to hospital 018 for evaluation and treatment of unstable angina. Alternative treatment plan questioned.	Letter sent on 7/12/85 to attending physician. No response to date.
10. Patient admitted to hospital 025. Presence of positive lab. test not adequately addressed.	Letter sent on 7/12/85 to attending physician. No response to date.
11. No history and physical in medical record. Initial H&H not documented prior to administration of transfusions. Hospital 011	Letter sent on 7/12/85 to attending physician. No response to date.
12. Evaluation of patient's back pain may have been incomplete. Hospital 013.	Letter sent on 7/12/85 to attending physician. No response to date.
13. Patient admitted to hospital 011 from a nursing home in septic shock. Patient was initially treated at another hospital. Quality issue concerns the fact that appropriate medical information was not made available to the Emergency Room staff.	Letters sent on 7/16/85 to attending physician, previous attending physician and administrators at the nursing home involved and at the hospital to which the patient was admitted. Response received by Health Care Review Inc. on 7/30/85 from indicated that historical information regarding the patients medical status was readily available to . He acknowledged, however, that the admission history did imply a communication problem.

Identified-Qualtiy Problems	Action Taken
14. Patient admitted to hospital 011. Treatment provided did not support the diagnosis of pneumonia.	Letter sent on 7/18/85 to attending physician. No response to date.
15. No pre or post transfusion hematocrit documented in patient receiving blood tranfusions at hospital 011.	Letter sent on 7/16/85 to attending physician. No response to date.
16. Patient admitted to Hospital 011 with abdominal pain and weakness. Severe cardiac Hx. Remained in ER 7 hrs. before EKG performed, Subjected to UGI Series, expired within few hours thereafter.	Reviewed by physician but action being held till Quality Committee meeting this month.
17. Patient admitted to Hospital 013 with abdominal and substernal pain. EKG changes could be interpreted as acute M.I. Lack of complete work-up, short 3 day hospital stay without treatment for M.I.	Identified by physician reviewer as quality problem. Action being held till Quality Committee meeting this month.
18. Acutely ill patient admitted to Hosp. 017 and subsequently died with septicemia. Inadequate monitoring of patient on I.V. Insulin drip, low value of 4 found in a.m. (no blood glucose done since 3 p.m. previous day)	Identified by physician reviewer as quality issue. Action being held till Quality Committee meeting this month.
19. Patient admitted to Hosp. 023 with bradyarrhythmia. Type of arrhythmia not documented--use of quinidine might not have been approrpriate, especially in heart block.	Quality issue identified by physician reviewer. Action being held till Quality Committee meeting this month.
20. Patient admitted to Hospital 020 with cardiac decompensation. Developed E. Coli UTI and bacteremia but was inappropriately heated with p.o. Erythromycin and discharged prematurely to N.H. on same medication. Re-admitted to Hospital 014 6 days later with E. Coli sepsis and died within 24 hours.	Identified as premature discharge with quality issue during U.R. physician review Referred to Quality Dept. Action held till Quality Committee meeting this month.

In all of the above cases a definite action has been initiated by the Quality Department of Health Care Review Inc. In addition, there are several other cases which are in the process of being reviewed by our staff or which are awaiting physician review.

The problem with AD hoc quality review which is essential to good quality medical care to Medicare beneficiaries-is the absence of HCFA contractual recognition and funding. Five quality objectives have been required by HCFA in its RFP; but the scope of quality review is far too narrow and such narrowing affects quality review performance of peer review organizations for Medicare. These 15 identified quality problems are the "tip of the iceberg" in our opinion. And they represent only Rhode Island. Real additional problems are the resources necessary to

CASES PENDING

IDENTIFIED QUALITY PROBLEM	ACTION TAKEN
21) Patient admitted to hospital 014 with possible bowel obstruction. Radiology identified possible obstruction or constucting lession. No further workup. Prem. D/C. Pt. re-admitted had surgery or atomic colon and ultimately expired after stormy post-op course	Case review'd by one surgeon, to be reviewed by second surgeon. Letter sent to attending on 8/1/85 in response to his letter concerning the premature discharge issue. Attending told of possible quality issue and that case will be further reviewed.
22) Patient admittted to hospital 023 with severe abd. pain. Secondary DX ileus yet patient fed low fat diet, without I.V.'s not NPO etc. P. dx - gastritis	Case reviewed by U.R. physician and quality issue identified. Further action pending Committe meeting.

Other cases ~~not~~ to be reviewed by physician

IDENTIFIED QUALITY PROBLEM	ACTION TAKEN
1) Patient admitted to hospital 012 for femoralpopliteal bypass. Question of occluded graft during 1st admission but attending disagreed. Patient re-admitted 6 days later with occlusion of graft.	To be reviewed by physician.
* 2) Patient to have O.P. cataract surgery, developed acute pulmonay edema. Surgery cancelled. admitted hospital 012. Serial enzymes consistent with "possible M.I." yet surgery performed anyways. Disch. then cancelled because enzymes became ⊕ for M.I.	To be physician reviewed. Rev. 9/22/85 by FSC → serious quality issue
3) Hospital 018. Premature disch. (pt. sent home without K+ supplement with ↓ K+). Quality issue - M.I. missed (episode of C.P., nausea, diaphoresis not responsive to NTG, ETG changes, ⊕ enzyme	Reviewed by U.R. physician for premature discharge. To be reviewed for quality issues.

4)	Patient admitted to hospital 013 with bladder outlet obstruction and recurrent *UTI's (urosepsis)* no urine C&S done before treatment started with I.V. Kefzol- need to identify specific organism.	Reviewed by U.R. physician for quality issue. Action held till Quality Committeee *meeting*.
5)	Premature disch. from hospital 013. Abnormal CXR, no follow-up or treatment for pneumonia. (without repeat blood cultures, without sputum C&S, without repeat CXR or repeat WBC). Re-admitted in 4 days with fever and chills pneumonia.	Reviewed by U.R. physician for premature discharge. Referred to Quality dept. for quality issue.

MAINE

Quality Problems identified in Maine are:

	Identified-Quality Problems	No Action Taken
1.	Hospital #39-Patient discharged 3 days post-op A/K amputation for gangrene foot no mention in path report of gangrene. Patient re-admitted 24 hours later and expired.	
2.	Hospital #15-Inappropriate pre-op evaluation - resulted in serious complication.	" " "
3.	Hospital #39-Uncommon complication occurring to patient during surgical procedure.	" " "
4.	Hospital #55-Patient expired - no code performed - no - no code order on chart.	" " "
5.	Hospital #009-Question of Unnecessary Surgery - post-op multiple post-op complications.	" " "
6.	Hospital #62-Principle symptoms not dealt with, patient discharge-threatened harm to public.	" " "
7.	Hospital #38-Patient diagnosed for possible malignancy, nothing done to R/O malignancy.	" " "
8.	Hospital #66-Surgical mis-adventure (serious)	" " "
9.	Hospital #34-Patient not treated for abnormal lab tests - disch. - readmitted died post-op after emergency surgery.	" " "
10.	Hospital #008-Physician did not deal with question of malignancy-patient ended up having radical surgery unnecessarily.	" " "
11.	Hospital #008-Know malignancy - tumor never staged - no chemo-radiation required radical surgery.	" " "

LESSER ISSUES REFERRED BY U.R. COORDINATOR"S

1) Severely ill 87 yr. old pt., no code. A fib not responsive to meds. Pt. agitated, kicking ?air hunger, 2:15 p.m. - 9:50 p.m. (expired) - issue involves lack of comfort measures to ease death (017)

2) Cataract outpt. Adm. after OR due to CP and EKG changes. Consult recommended telemetry overnight (not thought to be angina). No telemetry, no nurses notes till day of disch. Was pt observed? (020 - Fat).

3) Diabetic, on oral med. hospitalized, placed on insulin, tried to teach pt. self-administration of Insulin but pt. had difficulty [illegible] seeing, etc. Pt. put on Diabinese, discharged home with VNA, to call M.D. for appt. in 2 weeks. No blood glucose for 2 weeks: (023)

4) Pt. had exac. of COPD and pneumonia, no antibiotic ordered or given? treated for pneumonia (011)

5) Pt. placed on potent drug (mestinon) for myasthenia gravis. No doucmentation of reason for Pt.'s stay-to observe for muscle weakness, neuro. check, respiratory difficulty.

DEPARTMENT OF HEALTH AND HUMAN SERVICES

August 21, 1985

Larry Pitman
Executive Director
Kansas Foundation for Medical Care
2953 SW Wanamaker Drive
Topeka, Kansas 66614

Dear Mr. Pitman:

This is to provide further clarification regarding Transmittal No. 5 of the PRO Manual concerning unnecessary admissions, readmissions, and transfers.

Paragraph 3010 describes the types of prohibited actions which circumvent PPS and for which PROs are required to deny the second admission. Paragraph 3010 A. specifically covers "premature discharge of a patient that results in the subsequent readmission of the patient to the same hospital" (emphasis added). Paragraph 3010 B. refers to "readmission of a patient to a hospital for care that could have been provided during the first admission," but does not specify whether this also includes related admissions to different hospitals.

HSQB informs us that paragraph 3010 B. refers to situations where the patient was medically stable upon discharge but needed elective inpatient care which could have been provided during the first hospital stay. This paragraph was not meant to include related admissions to different hospitals. The second admission can only be denied when the patient is readmitted to the same hospital. If the patient is admitted to Hospital B for care which could have been provided during a previous admission to Hospital A, the case should be pursued as a quality issue only. Sanctions should then be applied as described in paragraph 3015 B.

If you have any questions on this issue, please feel free to contact me.

Sincerely yours,

Gregory A. Lear, Chief
Medical Review Branch
Division of Health Standards and Quality

HSQB:MRB. GALEAR:lr

FILE
COPY

OFFICE	SURNAME	DATE	OFFICE	SURNAME	DATE	OFFICE	SURNAME	DATE
MRB		8/21/85						

U S GPO: 1984 458 836

Reporting Date: 8 / 22 / 85

NDHCRI INCIDENCE REPORT TO REGIONAL OFFICE

Patient Name: ___________ HIC NO.: ________ Age: 81

Admit Date: 6 / 03 / 85 (5 22 85) Hosp. Name ________ MPR No.35-_____

Physician Name: Doctor ________ M.D. License No.: __________

Reviewer Numbers: R.S. [redacted] P.A. [redacted] Reviewed: 8 / 21 / 85

Incidence Type:

X A. Readmission Subsequent to a Pre-mature Discharge
___B. Transfer Of a Questionable Nature
___C. Hospital Initiated Denial Not Reported on Monthly List
___D. Inappropriate Hosp. Init. Den. Issued Prior to DRG ALOS

(Narrative description of the problem or discrepancy using as accurate direct language as possible. Use physicians orders and physician advisor notes for quotations where possible.)

The PA states: "Evaluation of this chart suggests that the patient was discharged too early. The WBC was consistently up, temp. was up during stay and chest findings by x-ray were never followed while in the hospital. In view of the fact the patient was admitted five days later with a right base pneumonia, temp. elevation and 23,000 WBC he probably should have been evaluated better before discharge. I suggest this goes to the Regional Office."

This patient was admitted 5/22/85 and discharged 5/28/85. The patient was readmitted on 6/3/85 and stayed until 6/10/85.

Distribution - Type	A B C D
NDHCRI	A B C D
Regional Office	A B C D
Hospital	A B C D
Attending Physician	A B C D
Fiscal Intermediary	D
Patient	D

August 23, 1985

Project Officer for OMPRO, MRB-DHSQ-X

Analysis of Oregon Medical Professional Review Organization (OMPRO) Contract Modification Request

Larry D. Camp, Chief
Medical Review Branch, DHSQ, Region X

Attached are OMPRO's requests for contract modification dated, 6/25 and 7/31. The initial request for an additional $128,015 was prompted by the staffing change made by OMPRO when we found its current contract DRG monitoring performance to be unsatisfactory. OMPRO revised its procedures as a result of our request for a corrective action plan, and requested additional money for the increased staff. We requested that OMPRO prepare a budget analysis regarding the current effect of all changes in the program. OMPRO's submittal shows $132,983 is the net effect of various other changes; an increase of about $4,000 over the initial request for DRG validation changes.

In my opinion, there is no justification for granting a contract amendment for additional work for the following reasons:

1. DRG validation activities now performed by OMPRO have always been required, and do not represent any new activity.
2. The savings accrued to OMPRO during the period it was not properly performing these activities far exceeds the $4,000 net cost increase for changed contract expectations.

Jerry B. Thompson

Attachment

8/27

MRB:JBThompson:im:8/22/85/REV 8/26
DOC 3769 File: OMPRO #3

THE KANSAS FOUNDATION FOR MEDICAL CARE INC.
2953 S.W. Wanamaker Drive / Topeka, Kansas 66614
Telephone: (913) 273-2552

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Kansas City

Vice President
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Newton

Secretary
Alex Scott, M.D.
Junction City

Treasurer
George R. Learned, M.D.
Lawrence

Executive Director
Larry W. Pitman
Topeka

Medical Director
G. Rex Stone, M.D.
Manhattan

August 26, 1985

Ms. Elizabeth Faykus
Contract Specialist
Department of Health and Human Services
Health Care Financing Administration
DPS/Contract Branch - RFP-HCFA-84-015
Room 322, East Highrise Building
6325 Security Boulevard
Baltimore, Maryland 21207

RE: HCFA 500-84-0506
#0117

Dear Ms. Faykus:

The purpose of this letter is to request a contract modification to contract 500-84-0506. The contract modification requests an increase in the level of effort and cost required to address the HCFA PRO medical determination validation contract with SysteMetrics.

The costs are associated with the following activities:

1. Communications with SysteMetrics, written and oral.

2. Notification to Kansas hospitals describing the purpose and objectives of the contract, explaining impact on individual hospitals and informing the hospitals that they will be paid 10¢ per page or the actual cost of photocopying each medical record, whichever is lower, and that arrangements for payment of postage and handling costs will be made.

3. Storage of one year of all medical records for medical reviews which are completed in KFMC's office.

9/11/85
[illegible] in Sept [illegible] 9/12/85.

4. Staff time, computer time and software development costs associated with providing SysteMetrics the necessary information to select records for review and to capture and provide review results to SysteMetrics on cases selected for review.
5. Staff time and associated costs for obtaining requested medical records in the possession of KFMC.
6. Staff time and associated costs for obtaining medical records from specific hospitals for selected stays.
7. Staff time and associated costs for identification and providing SysteMetrics information regarding KFMC's review/validation decisions of selected cases.
8. Staff time and associated costs for reviewing, commenting and provision of additional documentation regarding SysteMetrics reports.
9. Estimated costs for payment to the hospitals for the photocopied records, 10¢ per page, or actual costs, whichever is less, and payment for all postage and handling costs.
10. Staff time and associated costs for handling the receipt of invoices and payments to hospitals for said invoices.
11. Staff time and associated costs for reviewing all records before sending them to SysteMetrics so that those records do not have to be rerequested.

    I refer you to Attachment I for additional clarification of this item.
12. Staff time and associated costs including postage to ship medical records to SysteMetrics.

The total additional cost to KFMC is $30,735.14. We request a modification of the above referenced contract in this amount to address the increase in the level of effort required by the PRO medical determination validation contract.

As KFMC is already incurring costs for this activity, we would appreciate your prompt response to our request.

Thank you in advance for your assistance.

Sincerely yours,

Larry W Pitman

Larry W. Pitman
Executive Director

de

Enclosure

xc: Mrs. Brenda Burton, HCFA
Kansas City, Missouri

1040B-27/29

DEPARTMENT OF HEALTH AND HUMAN SERVICES

AUG 28 1985

Project Officer
HCFA, HSQ, HRB, Kansas City

Kansas Foundation for Medical Care HCFA-500-84-[illegible] Request for Contract Modification

Ms. Elizabeth Faykus
Contract Specialist, Contract Branch
Division of Procurement Services
Health Care Financing Administration
Room 385 East High Rise
6325 Security Boulevard
Baltimore, Maryland 21207

I received a copy of KFMC's August 12, 1985 letter to Bill Tate which outlined the additional costs they felt were needed as a result of the implementation of IM-85-2. This request was in response to the Changes Clause in their contract.

Below is my recommendation as to the appropriateness of their request.

		Request	Recommendation
1.	Printing and mailing expense for revised review plan.	$ 2,000	
	This is a reasonable request. They revised their review plan to portray activities for compliance with IM-85-2. There are 144 Kansas hospitals.		$2,000
2.	Copy and mailing of revised procedure for notification of attending physician of potential denials.	500	
	Delete. The potential denial notice process was not new as a result of IM-85-2. It has always been a requirement of PROs (including PSROs).		-0-
3.	Additional Physician reviewer expense - due to revised procedure for notifying attending of potential denials	42,120	
	Delete. Same reason as 2 above.		-0-

FILE COPY

OFFICE	SURNAME	DATE	OFFICE	SURNAME	DATE	OFFICE	SURNAME	DATE

4. 3 additional FTEs		
a) 1 FTE, coordinator for potential denial protocol	23,550	
Delete		-0-
b) 1 FTE, clerical to schedule reconsiderations	16,[illegible]	
Recommend $16,[illegible] be allowed for this activity.		16,[illegible]
c) 1 FTE for additional area review coordinator	23,550	
Recommend $23,550 be allowed for this activity		23,5[illegible]
5. Telephone expenses as a result of potential denial protocol	[illegible],000	
Delete. See 2 above.		-0-
6. Additional office space due to potential denial protocol	[illegible]	
Delete. See 2 above.		-0-
7. Programming changes in Medicare software generated by the [illegible]-85-2 implementation	17,300	
Recommend approval. Major software changes have been required to bring the requirements of 85-2 into place.		17,3[illegible]
TOTALS	$12[illegible],[illegible]20	5[illegible],7[illegible]

My total recommendation is that [illegible] be awarded $5[illegible],7[illegible] additional [illegible] for performance of reviews in accordance with [illegible].

[illegible] F. Carter

HCFA:DHSQ:MRB:BFB:jpk/08/28/85/264350

cc: Cindy Graunke OMR

BB

THE KANSAS FOUNDATION FOR MEDICAL CARE INC.
2953 S.W. Wanamaker Drive / Topeka, Kansas 66614
Telephone: (913) 273-2552

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Executive Director
Larry W. Pitman
Topeka

Medical Director
G. Rex Stone, M.D.
Manhattan

August 12, 1985

Mr. Bill Tate
Chief, Contract Branch
Health Care Financing Administration
6325 Security Boulevard
East Highrise Building Room 322
Baltimore, Maryland 21207

Dear Mr. Tate:

This letter constitutes a formal request for a modification of our PRO contract as a result of the implementation of IM 85-2. The following is a breakdown of the additional costs to KFMC above the original fixed price contract:

1. Printing and mailing expense for revised review plan. $2,000.00

2. Copying and mailing of the revised procedure for notification of attending Physicians of potential denials. 500.00

3. Additional Physician Reviewer expense required by the revised procedure for notifying attending Physicians of potential denials (780 hours Xs $54.00). 42,120.00

4. Three additional FTE's are required. 64,000.00
   a) One (1) FTE to coordinate the new procedure for the potential denial protocol. [illegible]

   b) One (1) clerical FTE to schedule reconsiderations. The new regulations re-established a 30 day turn-around time for reconsiderations requested by the hospital/attending. In order to meet this more restrictive time frame, additional staff is needed.

   c) One (1) FTE for an additional Area Review Coordinator. This new position is needed to absorb the additional review responsibilities contained in 85-2. These include:
      Calculation of quarterly denial rates for outliers.
      Requirement to notify hospital of preadmission results.

Reviewing for third-party liability.
Reopening previously denied cases if new information is provided.
Requirement to determine if medical necessity exists anytime during a hospital stay.
Requirement that we review for coverage issues.
Increased review responsibilities in the area of attestation statements and penalty statements.
Review of DRG 462.
Review of hospital requested claim adjustments.

5.	Additional telephone expense generated by the requirement to permit attending Physicians the opportunity to discuss potential denials	6,000.00
6.	Additional office space required for the handling of additional information resulting from the notification to attending Physicians regarding potential denials	2,000.00
7.	Programming changes in Medicare software generated by the implementation of 85-2	17,300.00

Therefore, it is requested that our contract be amended to include additional reimbursement in the amount of $133,920.00.

Sincerely yours,

Larry W. Pitman
Executive Director

LWP/GZ/de

xc: Ms. Brenda Burton, PRC Project Officer
Kansas City, Missouri
Ms. Elizabeth Faykus, Contract Specialist
HCFA, Baltimore, Maryland

1040B-9/10

cfmc
COLORADO FOUNDATION FOR MEDICAL CARE

Building 2, Suite 400
6825 E. Tennessee Avenue
P. O. Box 17300
Denver, Colorado 80217
Telephone (303) 321-8642

August 30, 1985

Mr. Jim Michie
Special Committee on Aging
United States Senate
Room SD-G33
Washington, D.C. 20510

Dear Mr. Michie:

I appreciated the opportunity to speak with you on Wednesday, August 28, concerning a variety of issues which describe the real world of operation of a Peer Review Organization.

As you indicated, our discussion did cover the areas of policy and procedure with the intent to identify which areas might require improvement through corrective legislation or other steps. As you know, we discussed the CFMC PRO operations concerning:

1. the initial negotiation process in Baltimore, the subsequent changes to the Scope of Work and the lack of CFMC success in securing additional dollars for perceived increases in Scope of Work;
2. Interim Manual 85-2 and the subsmission of this Manual to PROs six days prior to the requested date of implementation;
3. the need for a consistent voice from the Health Care Financing Administration in both chronologic terms and content terms of informing Fiscal Intermediaries and PROs of similar Scope of Work with similar time frame implementation requirements;
4. the concerns of negative cash flow recognizing that CFMC will be incurring on our $3.14 millon PRO budget over a $50,000 expense during the two year term of the contract for borrowed money costs or lost interest costs. This represents over the two year period, $40,000 of actual interest charges to be incurred due to the need to borrow funds resulting from negative cash flow as well as over $10,000 worth of lost interest due to CFMC utilizing its corporate working capital to fund the PRO cash flow needs;
5. in generic terms, the Scope of Work creep and the HCFA administration Scope of Work changes without corresponding approval from the Contract Officer prior to requested or required implementation; and

6. the need for additional resources to assess and address quality of care issues, whether the provision of additional money for work in the quality area would be of benefit and is truly needed.

We appreciate the opportunity to address these items in a spirit of constructive and corrective criticism acknowledging the awesome task of HCFA/HSQB in revising over 160 PSROs into the new PRO program and the successful operation of those 54 PROs. We are looking forward to the opportunity to meet with Mr. Steve McConnell of the Seantor's staff on Tuesday, September 3, as well as the opportunity to continue these discussions in the spirit of assuring that Medicare beneficiaries are receiving appropriate care in the appropriate type of facility to meet their medical needs.

Finally, enclosed for your consideration is a copy of correspondence to Mr. Bill Tate, Chief of Contracts, addressing several of the concerns which we spoke about during our phone coversation of Wednesday, August 28. We appreciate your interest in the successful operation of the PRO program and are available to answer subsequent questions which you may have concerning the Colorado experience as it applies to PRO program activities.

Sincerely,

Arja P. Adair Jr.

Arja P. Adair, Jr.
Executive Director

APA:eak

Enclosure

cc: William J. Osheroff, M.D., President, CFMC
Kenneth A. Platt, M.D., Medical Director, CFMC
Mr. Tom Langan, Chief, HCFA, Region VIII
Mr. Andrew Webber, Executive Vice President, AMPRA

[illegible] Hearing, [illegible]

cfmc

COLORADO FOUNDATION FOR MEDICAL CARE

Building 2 Suite 400
6825 E. Tennessee Avenue
P. O. Box 17300
Denver, Colorado 80217
Telephone (303) 321-8642

August 19, 1985

Mr. Bill Tate
Chief of Contracts
Contract Branch of HCFA
Department of Health and Human Services
Health Care Financing Administration
6325 Security Boulevard
Baltimore, Maryland 21207

Subject: Corespondence concerning Contract No. HCFA 500-840520, Letter No. 10, Regarding Letter No. 6 dated April 16, 1985, and Letter No. 7 dated May 16, 1985, and Letter No. 8 dated July 10, 1985

Dear Mr. Tate:

I appreciated the opportunity to speak with you Thursday afternoon concerning the content of our correspondence of July 10, 1985. As we discussed over the phone, the Foundation as the PRO for the State of Colorado has been required to make changes in its review activities, both by Interim Manual 85-2 and by Regulations dated April 16, 1985. Such changes have been, in the opinion of the CFMC, changes to the Scope of Work which resulted in additional work load. To-date, we are without a written response concerning the financial considerations which need to be made on this additional Scope of Work.

As we agreed, requests for changes in Scope of Work by the Health Care Financing Administration, Health Standards and Quality Bureau should be made only after approval by the Contracts Division when changes in Scope of Work occur. As you can see from a review of the materials submitted to you in our July 10, 1985 correspondence, the Colorado Foundation for Medical Care was required to make changes by the Baltimore PRO Program staff in order to remain in compliance with Medicare requirements even though such requirements were not reflected in our contract. As a result, we have made changes but have yet to receive any acknowledgment of our requested financial needs resultant from these program changes.

I appreciate your working directly with Mr. Don Tabor in addressing the correspondence of July 10 and will contact you prior to September 1, in order to secure a response concerning this correspondence. Thank you for handling these issues on a timely basis.

Sincerely,

Arja P. Adair Jr.

Arja P. Adair, Jr.
Executive Director

APA:eak
cc: Mr. Don Tabor
    Mr. Tom Langan
    Mr. Andy Webber
    Kenneth A. Platt, M.D.
    William J. Osheroff, M.D.

... PRO Division

Joyce Divers' Don Tabor:

[illegible]

Bill Tate - 301 594 3139

discussed w/ Bill Tate 8/14 see letter

discussed w/ Don Tabor 8/1 - see letter

called Don Tabor 8/28 - out 4:pm

Bill Tate 8/28 - in mtg 4pm - left word to call back

cfmc
COLORADO FOUNDATION FOR MEDICAL CARE
Building 2. Suite 400
6825 E. Tennessee Avenue
P. O. Box 17300
Denver. Colorado 80217
Telephone: (303) 321-8642

July 10, 1985

Mr. Bill Tate
Chief of Contracts
Contract Branch of HCFA
Department of Health & Human Services
Health Care Financing Administration
6325 Security Boulevard
Baltimore, Maryland 21207

Subject: Contract No. HCFA-500-84-0520 - No. 8
Regarding Letter No. 6 dated April 16, 1985 and
Letter No. 7 dated May 16, 1985

Dear Mr. Tate:

I am writing to express my concern over the lack of timeliness of the Health Care Financing Administration in responding to change of work requests under the PRO Contract process.

The Foundation has submitted two contract modifications to the Health Care Financing Administration. The first concerns changes to our contract requiring mandatory 100% preadmission review. This is documented by correspondence to Mr. Donald R. Tabor, dated April 16, 1985. The second concerns the change in scope of work directed by Interim Manual 85-2, sent to Mr. Donald R. Tabor, dated May 16, 1985. To-date, the Foundation is without written response from either Mr. Tabor or the PRO Program Staff of the Health Care Financing Administration in Baltimore posing the CFMC both contractual and financial concern.

As was anticipated by both parties, the PRO Program Staff at the Health Care Financing Administration in Baltimore, by contract, does reserve the right to issue additional directives. Such directives are to be evaluated by each PRO and when the PRO indicates an increase in work, the contract calls for timely disposition of such requests from the PRO by the Health Care Financing Administration. Submission of the initial change of work order, on April 16, 1985, return receipt requested, has not resulted in any written response from the HCFA Central Office to-date. The Foundation is currently not operating according to its existing contract which requires a selective preadmission review process (see enclosure), but is operating in accordance with HCFA Program Staff written requests (correspondence of Mr. Tom Langan dated April 15, 1985 enclosed). We know that our Regional Project Officer has himself acted expeditiously. However, correspondence which should come from Mr. Tabor, whether generated by Mr. Tabor or generated through the PRO Program Staff in Baltimore, has yet to be received.

Similarily, our request of May 16, 1985, concerning change in scope of work directed by Interim Manual 85-2 remains unanswered. Both these program changes were implemented by the Colorado Foundation for Medical Care effective July 1, anticipating an expeditious or at least timely response to our request for increased reimbursement as a result of the increase in work requested by HCFA PRO Program Staff in Baltimore and our Regional HCFA Office.

Listed below is the correspondence in chronological order, not including the numerous telephone conversations, with the HCFA Offices to secure a response to both of these issues:

1. Colorado Foundation for Medical Care Memorandum from Ms. Judie Lenhart and Ms. Joanna Rowe to Mr. Adair dated April 12, 1985 concerning the Medicare Transmittal #IM 85-2: Projected Changes.

2. Letter from Mr. Tom Langan to Mr. Adair, dated April 15, 1985, concerning #IM 85-2.

3. Letter from Mr. Adair to Mr. Donald R. Tabor, dated April 16, 1985, with six attachments listed in the letter, concerning Preadmission Review - Change in Scope of Work - Letter No. 6.

4. Letter from Mr. Adair to Mr. Donald R. Tabor, dated May 16, 1985, concerning Cost Proposal to Implement Change in Scope of Work Directed by #IM 85-2 to Contract No. HCFA-500-84-0520 - Letter No. 7.

5. Letter from Mr. Tom Langan to Mr. Adair, dated June 19, 1985, concerning the contract modification to perform 100% preadmission review.

In order to allow the Colorado Foundation for Medical Care to complete its obligations for the PRO Medicare Review Program, this PRO has to have a timely response from its contractor in the same manner which we work with our private contracts and Colorado Medicaid. We are frustrated by the lack of responsiveness out of the PRO Program Division in Baltimore despite direct and indirect discussions with Mr. Nathanson and Mr. Tirone, and direct written request to Mr. Tabor.

We would appreciate your looking into these two items to secure an immediate written reply on both requested changes in scope of work items at your earliest convenience, preferrably no later than July 24, 1985. The Colorado Foundation for Medical Care intends to use its best professional efforts to meet the requirements of the PRO Program. Without timely completion by PRO Program Staff and the Contracts Office of their contractual obligations, we are hard pressed to assure new obligations without increased funding. The PRO Contract speaks for itself on our respective responsibilities in this area.

We request timely performance by Contracts and the HCFA PRO Program Staff in Baltimore to assure contract compliance through timely handling of changes of work orders in the same manner that Baltimore and our Regional Office continue to monitor the performance of this and all other PRO's.

Sincerely,

Arja P. Adair Jr. ✓

Arja P. Adair, Jr.
Executive Director

APA:eak

Enclosures

cc: Carolyne Davis, Ph.D., Administrator, HCFA
    Mr. Phil Nathanson, Director, HCFA
    Mr. Anthony Tirone, Director, OMR/HSQB
    Mr. Donald R. Tabor, Contract Specialist, HCFA
    Mr. Tom Langan, Chief, HCFA, Region VIII
    William J. Osheroff, M.D., President, CFMC
    Kenneth A. Platt, M.D., Medical Director, CFMC
    Mr. Andrew Webber, Executive Vice President, AMPRA

COLORADO FOUNDATION FOR MEDICAL CARE

ATTACHMENTS TO LETTER DATED JULY 10, 1985 TO MR. BILL TATE PERTAINING TO MANDATORY 100% PREADMISSION REVIEW

1. Letter dated April 15, 1985 from Mr. Tom Langan to Mr. Arja P. Adair, Jr.
2. Letter dated April 16, 1985 from Mr. Arja P. Adair, Jr. to Mr. Donald R. Tabor including six attachments.
3. Letter dated June 19, 1985 from Mr. Tom Langan to Mr. Arja P. Adair, Jr.

DEPARTMENT OF HEALTH & HUMAN SERVICES

Health Care Financing Administration

Region VIII
Federal Office Building
1961 Stout Street
Denver CO 80294

bill

April 15, 1985

Mr. Arja P. Adair, Jr.
Senior Vice President
Colorado Foundation for Medical Care
6825 East Tennessee Avenue, Building 2,
Suite 400
Post Office Box 17300
Denver, Colorado 80217

Dear Mr. Adair:

Please comply with my letter of April 4, 1985 to you relative to the Colorado Foundation implementing the preadmission review program by April 19, 1985, as described in the Peer Review Manual, March 1985 (IM 2003.6), Page 13 and Page 17.

In discussions with Health Standards and Quality Bureau, the management staff has clearly directed me to advise the Foundation to immediately implement 100% preadmission review and modify the PRO/FI MOU accordingly.

The PRO contract requires that the Foundation modify their preadmission review approach immediately, and if interested, subsequently document for HCFA consideration, the ramifications of the changes required in terms of staffing and administrative concerns.

Sincerely yours,

Tom Langan

Tom Langan, Chief
Medical Review Branch
Division of Health Standards and Quality

cc:
Anthony J. Tirone
Donald R. Tabor

cfmc
COLORADO FOUNDATION FOR MEDICAL CARE

Bu[illegible]
6825 E Te[illegible]
[illegible]
Denver C[illegible]
Telephone [illegible]

April 16, 1985

Mr. Donald R. Tabor
Contract Specialist
Department of Health and Human Services
Health Care Financing Administration
DPS/Contract Branch, Room G-10-A EHR
6325 Security Boulevard
Baltimore, Maryland 21207

Subject: Contract No. HCFA-500-84-0520 - No. 6
Pre-admission Review - Change in Scope of Work
to CFMC Fixed Price Contract

Dear Mr. Tabor:

The purpose of this letter is to complete the process initiated on April 10, 1985 concerning the Health Care Financing Administration's request that the Colorado Foundation for Medical Care change the pre-admission review approach from that currently used by CFMC under its PRO contract. Attached for your information are the following documents:

1. Section III. B. 9., 10., 11., 12., 13., 14., 15., 16., 17., 18., from the initial PRO proposal by the CFMC dated April 27, 1984 which describes the Foundation's proposed process of selective pre-admission.

2. Letter dated June 29, 1984 to Mr. Donald R. Tabor which describes under Attachment F a clarification regarding the CFMC's pre-admission review methodologies ("selected pre-admission review" and "100% pre-admission review").

3. Attachment F from the June 29, 1984 letter above referenced.

4. Memorandum from Bill Wood to Judie Lenhart dated April 9, 1985 concerning the additional cost of the Medicare Contracts for 100% pre-admission review. As noted in this memorandum, the costs are estimated to be $139,058 for the period of the twelve months estimated or an additional $11,588.17 on a monthly basis for the months remaining in the contract after a date of implementation has been agreed upon.

5. A copy of the letter from Tom Langan dated April 4, 1985 which relates the opinion of Dr. Zellinger concerning the requirement to abide by the contract and the specific guidance provided in the Peer Review Organizational Manual dated March, 1985.

6. Letter from Arja P. Adair, Jr. to Tom Langan dated March 28, 1985 explaining the Foundation's pre-admission review program as approved by the Department of Health and Human Services in the contracting process of June and July, 1984.

The above referenced enclosures are used as documentation to indicate that the CFMC is currently performing pre-admission review as it proposed. The Foundation considers the HSQB Department instructions to revise the pre-admission review from the configuration originally negotiated as a change in scope of work to the Fixed Price Contract. Secondly, that the CFMC is willing to implement a revised system pursuant to the request of the Health Care Financing Administration upon negotiation and agreement of a change order to the contract which redefines and reimburses the CFMC for the increased work load. We accordingly ask for the Contract Officer to acknowledge this increase requirement of work above and beyond that negotiated during the June and July, 1984 negotiation as above documented and request authorization from the Contracts Office to bill the Federal Government for $11,588.17 per month for each of the remaining months of the contract that the Foundation performs pre-admission review as required by Dr. Zellinger and the Health Care Financing Administration.

Should you need any questions answered concerning the basis behind this request or have questions concerning the content of the attachments, please feel free to contact either Dr. Platt or me at your earliest convenience.

Sincerely,

Arja P. Adair Jr.

Arja P. Adair, Jr.
Senior Vice President

APA:eak

Attachments

cc: Kenneth A. Platt, M.D.
William J. Osheroff, M.D.
Mr. Hank Rael
Ms. Judie Lenhart
Mr. Tom Langan
Mr. Andy Webber

2. PREADMISSION REVIEW

#1

a. INTRODUCTION

To encourage the appropriate utilization of inpatient hospital services, selected elective cases from selected procedure related DRG's will be reviewed prior to admission to determine the medical necessity for admission, effective for Medicare admissions on or after July 1, 1984. The purpose of preadmission review is to reduce admissions for procedures that could be performed effectively and with adequate assurance of patient safety in an ambulatory surgical setting or an outpatient basis; and for those procedures where inpatient hospitalization is required to perform the procedure, to assure the medical necessity to have the procedure performed.

The procedures which will have selective preadmission review performed if inpatient hospitalization is required versus outpatient surgery are as follows:

DRG	ICD-9-CM Code	Procedure
6 (carpal tunnel release)	04.43	Carpal tunnel release
39 (lens procedures)	13.11	Intracapsular extraction of lens by temporal inferior route
42 (intraocular procedures ~~except~~ except retina, iris, & lens)	13.19	Other intracapsular extraction of lens
	13.2	Extracapsular extraction of lens by linear extraction technique
	13.3	Extracapsular extraction of lens by simple aspiration (and irrigation) technique
	13.41	Phacoemulsification and aspriation of cataract
	13.51	Extracapsular extraction lens by temporal inferior route
	13.59	Other extracapsular extraction of lens

	13.62	Excision of primary membranous cataract
	13.65	Excision of secondary membrane (after cataract)
	13.69	Other cataract extraction
	13.70	Insertion of pseudophakos, not otherwise specified
	13.71	Intraocular lens prosthesis at time of cataract extraction, one-stage
	13.72	Secondary insertion of intraocular lens prosthesis
	13.8	Removal of implanted lens
225 (foot procedures)	79.38	Open reduction, internal fixation, toe
	79.98	Unspecified operation on toe injury
	81.16	Metatarsophalangeal fusion
	81.18	Other fusion of toe
	84.11	Amputation of toe
161, 162, 163	53.00	Unilateral inguinal hernia repair

It is recognized that the outpatient setting is not appropriate for all patients undergoing one of the previously listed procedures, and criteria will be developed to indicate the exceptions for the use of an ambulatory setting when inpatient hospitalization is justified.

Additionally, the following procedures are appropriately performed on an inpatient basis, if there is medical necessity for the procedure to be performed:

DRG	ICD-9-CM DOE	PROCEDURE
116 (Permanent Cardiac Pacemaker w/o AMI or CHF)	37.70	Insertion of cardiac pacemaker, not otherwise specified
	37.73	Insertion permanent pacemaker into atrium, transvenous route
	37.74	Insertion permanent pacemaker into ventricle, transvenous route
	37.75	Insertion permanent pacemaker into unspecified site, transvenous route
	37.76	Insertion permanent pacemaker into epicardium
	37.77	Insertion of permanent pacemaker, unspecified approach
225 (foot procedures)	77.51	Bunionectomy with soft tissue correction and ostectomy of the first metatarsal
	77.52	Bunionectomy with soft tissue correction arthrodesis
	77.53	Other Bunionectomy with soft tissue correction
	77.54	Excising bunionette
	77.59	Other Bunionectomy

The CFMC review process will include selective preadmission review and retrospective monitoring as follows:

(1) Physicians and hospitals will be provided with criteria which differentiate between patients who can have surgery performed on an inpatient versus an outpatient basis, or if the procedure is one which is appropriately performed in an inpatient setting, criteria for medical necessity to perform the procedure.

(2) Prior to admitting a patient on an inpatient basis for one of the selected procedures, the physician will apply the criteria to determine whether the patient meets criteria for inpatient hospitalization, or if the procedure is one which is appropriately performed on an outpatient basis, criteria for medical necessity will be applied.

(3) If the patient does not meet criteria for inpatient hospitalization or for the procedure, but inpatient hospitalization or performance of the procedure is deemed to be appropriate, the physician's office must contact the CFMC Regional Office for review.

(4) The CFMC Regional Office, after contact with the Physician Advisor, will notify the attending physician as to whether inpatient hospitalization or performance of the procedure is approved or denied.

(5) As a result of this review process, all inpatient hospitalizations for the selected procedures should be appropriate, either according to criteria or approved by the CFMC Physician Advisor. To assure the appropriateness of inpatient hospitalization for these proecedures, the CFMC will retrospectively monitor cases for which one of the selected procedures is performed on an inpatient basis. Any admission for one of the selected procedures which occurs without CFMC approval, that is subsequently determined not to be medically necessary will be retrospectively denied.

b. SELECTIVE PREADMISSION REVIEW

(1) TIMING OF REVIEW

The physician's office must contact the CFMC Regional Office for admission approval at the point in time that a patient is scheduled for inpatient hospitalizaton for one of the selected procedures if criteria for inpatient hospitalization or for the procedure are not met. If the patient is already in the hospital when it is determined that one of the selected procedures (e.g. permanent pacemaker insertion) is to be performed on a patient that does not meet criteria, the physician's office must contact the CFMC Regional Office prior to performing the procedure to obtain CFMC approval. In the instance of an emergency admission which does not meet the criteria for inpatient hospitalizaton, the physician's office must notify the CFMC Regional Office of the admission by telephone within 24 hours or the first working day after admission.

The CFMC Regional Office must make a decision on the necessity for inpatient hospitalization for the procedure within forty-eight (48) hours (excluding weekends and holidays) after telephone contact. The physician's office will be notified via phone within forty-eight (48) hours to be followed by written confirmation within three (3) working days.

(2) R.N. COORDINATOR REVIEW

(a) MEDICARE PREADMISSION REVIEW WORKSHEET

A CFMC R.N. Coordinator in the CFMC Regional Office will document the information received from telephone review on the Medicare Preadmission Review Worksheet (refer to Attachment D, page E-271).

The worksheet will document the physician's specific reason why the procedure cannot be performed on an outpatient basis, or in the instance of permanent pacemaker insertion or bunionectomy, why the procedure is to be performed.

All cases will be referred to the Physician Advisor for review and determination for the medical necessity for inpatient versus outpatient hospitalization, or the medical necessity for the procedure. The specific reason for the Physician Advisor's approval or denial determination will be documented on the worksheet. The Preadmission Review Worksheet will be attached to the appropriate hospital Preadmission Review Log and will be used to complete the Regional Preadmission Review Activity Report (refer to Attachment E, page E-272).

(b) MEDICARE PREADMISISON REVIEW LOG

The CFMC R.N. Coordinator will complete a Medicare Preadmission Review Log (Attachment E, page E-272) by hospital for each case reviewed. A copy of the Preadmission Review Log will be provided to the CFMC R.N. Coordinator conducting retrospective monitoring for the hospital.

(3) PHYSICIAN ADVISOR REVIEW

The Physician Advisor will determine whether inpatient hospitalization is required and/or if the procedure is medically necessary.

(4) INPATIENT HOSPITALIZATION AND PROCEDURE APPROVAL LETTER

If inpatient hospitalization and/or the procedure is approved, the attending physician and the hospital will be notified in writing within three (3) working days of the determination (refer to Attachment F, page E-273).

The Inpatient Hospitalization and Procedure Notification Letter will be written on CFMC Regional stationery and will be addressed to the attending physician.

A copy of the Approval Notification Letter will be given to the hospital admission office to be placed in the patient's medical record so that it will be available for review by the CFMC R.N. Coordinator when performing retrospective monitoring.

c. PREADMISSION DENIAL NOTIFICATION

(1) PREADMISSION DENIAL NOTIFICATION

If denial occurs as a result of the preadmission review, the patient or his/her representative, attending physician, hospital administration, hospital billing department, CFMC Regional and Central Offices and the Fiscal Intermediary will be notified in writing within three (3) working days of the denial determination.

The Preadmission Procedure Non-Certification Letter (refer to Attachment G, page E-274) will be written on CFMC Regional stationery and will be addressed to the attending physician. The procedure which is being denied will be recorded. The specific reason for the denial determination will be documented. The letter advises the patient or his/her representative, attending physician and the hospital of their rights for an appeal of the denial determination. The letter must be signed by the Physician Advisor and dated. Copies of the denial letter will be distributed to the aforementioned parties. A copy of the denial letter, along with the Preadmission Review Worksheet, will be attached to the CFMC Regional Preadmission Review Report (Attachment E, page E-272).

(2) PREADMISSION APPEAL PROCEDURE

The appeal procedure for a preadmission denial is the same as described under the PPS Review Appeal Procedure, (refer to Section B.10, pageB B1), except that the CFMC Regional Appeals Panel has three (3) working days from the date of written appeal request in which to make an appeal determination.

(3) INPATIENT DENIAL LETTER

If the patient is an inpatient when denial occurs, the Inpatient Procedure Denial Letter will be distributed as described under the Preadmission Denial Letter (part c above). Under provisions of waiver-of-liability, the patient cannot be billed by the hospital for services that are retrospectively denied.

(4) INPATIENT APPEAL PROCEDURE

The appeal procedure for an in-house denial is the same as described under the PPS review appeal procedure, except that a request for appeal of an inhouse patient should be made within 24 hours or the first working day after written denial notification and the CFMC must make a determination within 3 working days of the request.

d. CFMC PREADMISSION REVIEW REPORT

Each CFMC Region will complete a Preadmission Review Report (Attachment I, page E-278) summarizing preadmission review activity by hospital on a monthly basis. Each report will cover the review activity completed in one month. Preadmission review activity will be reported only after all review, including appeal, has been completed. The CFMC region will mail the Preadmission Review Report to the CFMC Central Office along with the CFMC Regional PPS Medical Review Activity Report (refer to Section B.11, page

e. RETROSPECTIVE MONITORING

(1) INTRODUCTION

The CFMC will retrospectivly monitor cases of hospitalization in which one of the selected procedures was performed. Any of these procedures that were performed on an inpatient basis without CFMC approval, may be retrospectively determined not to be medically necessary and may be retrospectively denied.

(2) TIMING OF REVIEW

These cases will be reviewed at the same time that PPS review activity is performed. (Refer to Admission Review (general) Procedure, Section B.3.a, page B-19).

(3) CASE IDENTIFICATION

Cases for review will be identified via the Medicare Discharge Log (either the manually produced Medical Discharge Log or the FI data tape).

(4) SELECION OF CASES FOR REVIEW

The Medicare Preadmission Review Log (Attachment E, page E-272) will be compared to the Medicare Discharge Log. All of the selected procedures that did not have preadmission review and approval will be reviewed retrospectively. For review of Permanent Pacemaker Insertions refer to procedure, page B-39 .

(5) OBTAINING MEDICAL RECORDS FOR REVIEW

The CFMC will send a Medical Records Request for PPS Review Letter (Attachment K, page E-1) to the hospital medical records department requesting the medical records needed to perform review. The request must be dated at least thirty (30) days proir to the date on which medical records are requested. If a medical record is not available on the date specified in the letter of request, the claim will be denied (refer to Admission Review (general) Procedure, Administrative Denial, Section B.3.a, page

(6) REVIEW PROCESS

(a) MEDICAL RECORDS REVIEW (Administrative Denial)

The CFMC R.N. Coordinator will review to determine that all the medical records requested are available for review.

If the hospital does not provide the CFMC with a medical record needed to perform review, the CFMC R.N. Coordinator will send a second notificaion letter to the hospital by certified mail informing them that the medical record must be delivered to the CFMC Regional Office by a specified date (within ten (10 calendar days of the notification), or a copy of the second notification letter will be forwarded to the Fiscal Intermeditary and the claim will be administratively denied. (Refer to Admission Review (general) Procedure, Administrative Denial, Section B.3.a, page B-19).

(b) COORDINATOR REVIEW

The CFMC R.N. Coordinator will review each case according to the appropriate procedure criteria. If criteria justifying inpatient hospitalization, or medical necessity for the procedure are met, the R.N. Coordinator may approve the case. The Coordinator will refer any case in which criteria guidelines are not met, or if met are questioned, to the Physician Advisor for review and determination of the medical necessity and appropriateness of the procedure, and/or inpatient hospitalization for performing the procedure.

(c) PHYSICIAN ADVISOR REVIEW

If the medical record in the medical judgment of the Physician Advisor contains sufficient information to justify the procedure and/or inpatient hospitalization to perform the procedure based on medical necessity (whether or not screening criteria are met), the Physician Advisor may approve inpatient hospitalization for the procedure.

If the medical record in the medical judgment of the Physician Advisor does not contain sufficient information to justify the procedure and/or inpatient hospitalization to perform the procedure, the Physician Advisor must make a reasonable attempt to contact the attending physician either by telephone or letter (Refer to Physician Advisor Letter to Attending Physician, Attachment B, page
The attending physician will be given one week to respond to either verbal or written contact or it will be denied (Refer to Denial Procedure, Section B.9, page

If the Physician Advisor after contact with the attending physician determines that inpatient hospitalization for the procedure is medically necessary and appropriate, the case will be approved.

If the Physician Advisor after contact with the attending physician determines that the procedure and/or inpatient hospitalization for the procedure is not medically necessary, the case will be denied. (Refer to Denial and Appeal Procedure, below).

All cases which are referred to the Physician Advisor must be documented on the PPS Review Document indicating the reasons for the Physician Advisor's approval or denial.

(7) DENIAL NOTIFICATION

Within three (3) working days of a denial determination, the CFMC will send a Retrospective Denial Notification letter to the patient or his/her representative, attending physician, hospital billing department, hospital administration, CFMC Central Office and the Fiscal Intermediary. A copy of the denial letter will be filed in the CFMC Regional Office (for Permanent Pacemaker Insertion refer to Section B.4.a, page B-39).

The denial letter will be written on CFMC Regional stationery. The denial letter will be addressed to the attending physician with copies provided to the aforementioned parties. The CFMC Regional Office will retain a copy of the denial letter for their files. A copy of the denial letter and the PPS Review Document will be attached to the monthly CFMC Regional Report of PPS Medical Review Activity (refer to Section B.11, page B-84).

The denial letter will document the specific reason for the denial determination. The denial letter states that beneficiaries may not be held responsible for charges for services furnished by the hospital in connection with unnecessary admission or other inappropriate medical practices in accordance with Section 602(f)(1) of Public Law 98-21. Beneficiaries may be charged only for deductible and co-insurance amounts. This section will be highlighted (e.g. with a yellow marker) on the denial letter which is sent to the patient or his/her representative. The denial letter informs the patient or his/her representative, attending physician and the hospital of their rights of appeal when denial occurs. The denial letter must be signed by the Physician Advisor and dated.

(8) APPEAL PROCEDURE

Refer to PPS review appeal procedure, page

(9) REPORTING

Procedures except pacemaker insertion which are reviewed as a part of retrospective monitoring will be included in the CFMC Regional Report of PPS Medical Review Activity. Refer to Permanent Pacemaker Procedure, Section B.4.a, page for reporting procedures.

10) INTENSIFICATION OF REVIEW

Based upon the PPS Medical Review Activity Report, the CFMC will intensify review as described below.

If a pattern is detected, the CFMC will institute appropriate action, examples of which include but are not limited to:

(a) Institute communication/educational efforts with the hospital and its personnel (this may include physicians).

(b) Institute intensive prepayment review for physicians with a pattern of noncooperation.

(c) If a pattern of abuse continues after CFMC efforts of discussion and corrective action, a sanction recommendation by the Board of Directors will be made to the Secretary of the Department of Health and Human Services (refer to Section C.2., page B-109).

cfmc
COLORADO FOUNDATION FOR MEDICAL CARE

Building 2, Suite 400
[illegible] East Tennessee Avenue
Denver, Colorado 80224
Telephone (303) [illegible]

#2

June 29, 1984

Mr. Donald R. Tabor
Contract Specialist HCFA
Contract Branch, DPS
Room 6-10-A, East High Rise Building
6325 Security Boulevard
Baltimore, MD 21207

Dear Mr. Tabor,

The Colorado Foundation for Medical Care has made revisions pursuant to our in-person discussions of June 25 and 26 in the PRO Technical Proposal for Operation of a Utilization and Quality Control Peer Review Organization (RFP-HCFA-84-015) as outlined below:

Attachment A

It was requested that the CFMC provide clarification of the rationale for the development of an objective regarding coronary bypass surgery. This clarification has been included in Attachment A.

Attachment B

It was requested of the CFMC that the number of deaths due to acute myocardial infarction to be reduced be stated in specific terms. The objective has been revised to include such specificity. Please refer to page III A 117 for the interventions to be used for physician corrective action. Attachment B contains pages which should be substituted in the objective "Reduce Avoidable Deaths."

Attachment C

Additional information has been included in Attachment C which details the proportion of DRG 243 discharges which are readmissions. The figures in the revised objective of June 11, 1984 do, in fact, reflect reductions in hospitalizations and not a shifting to outpatient hospital care.

Attachment D

Clarification was requested from HCFA regarding a baseline rate for the number of urinary tract infections in Colorado. This information has been included in the substitute pages attached for that objective. Please note on page 136 the changes made which substantiate the 20% inappropriate use.

psro COLORADO'S PROFESSIONAL STANDARDS REVIEW ORGANIZATION

Attachment E

It was unclear to HCFA that in the objective on foot procedures (DRG 225) the CFMC would impact in two separate areas, "admissions for procedures that could be performed effectively and with adequate assurance of patient safety in an ambulatory surgical setting or on an outpatient basis" and the area of "inappropriate or unnecessary admissions or invasive procedures by specific practitioners or in specific hospitals". This is more clearly stated in the attached revised objective. CFMC believes that bunionectomies, if necessary, are properly performed on an inpatient basis. The number of bunionectomies performed will be reduced via a 100% preadmission review methdology in three hospitals and retrospective review at the remaining Colorado hospitals. There are four toe procedures which are done with some frequency on an inpatient basis which could be safely performed on an outpatient basis. There will be a reduction in the number of such procedures performed on an inpatient basis as a result of the review methodology listed above.

Revised pages for this objective are attached as attachment E.

Attachment F

HCFA asked for clarification regarding the CFMC's preadmission review methodologies ("selected preadmission review" and "100% preadmission review"). A clarification is included as attachment F.

Attachment G

The CFMC's quality objective on decubitus ulcers was deleted at the request of HCFA. A substitute objective regarding the monitoring of patients on aminoglycoside antibiotics has been prepared and is included as attachment G.

Attachment H

For other objectives, DRG 294, DRG 134, DRG 39, DRG 116, DRGs 161-162, DRG 42, and DRGs 106-107 revised implementation schedules have been proposed which outline the cases to be reduced in every area by quarter, per year, and for the contract period.

PHDDS tape

The Foundation's data subcontractor, Commonwealth Clinical Systems, will be submitting a 1982 tape with 114,312 records and an 1983 tape with 117,331 records on it to Don Sikora on Monday, July 2nd. The 1983 tape has 13,099 records which will not pass PHDDS edits and are only provided to provide a numbers count. These records are in the process of being corrected. Taking the 114,312 x 1.0298 equals 117,718 for 1983 and this number x 1.0298 equals 121,226, slightly lower than the 121,711 which we requested. As a result of these calculations, we request our awarded amount reflect the additional work load required as a result of the additional 6,045 for year 1 and the anticipated 6,021 additional for year 2. This has been calculated as follows:

(121,226 x 1.0298) - 118,818 = 6021.

We await your response after your discussion with Mr. Sikora.

page 3
June 29, 1984

It is the intent of the CFMC to develop objectives to address the request of HCFA to reduce 4000 additional admissions over a two year period. These objectives are in the process of development and will reflect a reduction in admissions in the following DRGs: 88, 89, 90, 91, 96, 97, 98, 99, 100, 101, 102, (Respiratory diseases - 2,400 cases reduced); DRG 243 (Medical Back Pain - 200 admission cases reduced in addition to the 200 readmissions outlined in the Medical Back Pain Objective); and DRG 182 (digestive disorders - 1400 cases reduced). It is understood that the CFMC will make denials only due to lack of medical necessity or inappropriateness of care.

We believe that the above referenced information fully responds to your requests. Upon review, should you require further information or clarification please contact us. Based upon this information submitted and the action of our Board of Directors, we remain committed to working with HSQB to resolve our differences into an acceptable and mutually compatible contract.

Sincerely,

Kenneth A. Pratt, M.D.
Medical Director

Enclosures

Included in Attach. F
June 25

COLORADO FOUNDATION FOR MEDICAL CARE

#3

PREADMISSION REVIEW FOR PRO

A SUMMARY

There are two types of preadmission review strategies which will be used by the Colorado Foundation for Medical Care under the PRO contract. They differ in intensity and will be used in different circumstances depending upon the of problem identified and the stage of implementation in process.

The less intensive alternative is refered to in the objectives as "selective preadmission review". This alternative involves the attending or admitting physician using criteria supplied by the CFMC to pre-screen cases which the physician would like to admit to the hospital. Using these criteria, the physician can determine whether or not the patient meets guidelines for admission and on that basis make a decision about whether admission is appropriate. If the physician believes that admission is appropriate even though the case does not fit in with the guidelines or criteria supplied by CFMC, the physician would be required to contact the CFMC for preadmission authorization. In all cases for the DRGs or procedures subject to selective preadmission review, the cases admitted to the hospital for the procedure or with the DRG under scrutiny would be reviewed retrospectively to determine whether the physician made appropriate decisions regarding the need for hospitalization and whether the physician sought preadmission authorization when required (i.e. when the patient did not meet criteria for admission).

For example, the CFMC has stated that carpal tunnel release procedures can safely be performed on an outpatient basis in most cases. The CFMC has criteria which outline in what instances the performance of this procedure on an inpatient basis may be appropriate. If the physician is going to perform a carpal tunnel release procedure on a patient with severe systemic disease (this is one of the circumstances under which the CFMC has stated that inpatient care may be more appropriate) the physician does not have to call the CFMC for preauthorization review. The physician can admit the patient and perform the procedure. The case will be reviewed retrospectively by the CFMC to determine whether or not the physician's judgement about the patient meeting criteria for hospitalization was correct. If it is found that the physician does not make appropriate decisions regarding whether to seek preauthorization review, the physician will be placed on 100% preadmission review. This means that the physician must call for all admissions for carpal tunnel release regardless of whether or not criteria for admission are met or not.

PREADMISSION REVIEW FOR PRO

As another example, the CFMC has established criteria for pacemaker insertion. If a physician wishes to insert a pacemaker, the physician will review the patient's case against the CFMC pacemaker insertion criteria. If the patient does not meet the criteria, yet the physician believes that insertion of the pacemaker is appropriate, the physician will be required to contact the CFMC for pre-procedure authorization. Again, all cases of pacemaker insertion will be retrospectively reviewed to determine whether the criteria are being used appropriately and if not, 100% preadmission review may be required.

All preadmision reviews of this "selective" type will require a judgement by a CFMC physician advisor since it is already known that the case does not meet screening criteria.

The 100% preadmission review program is a form of corrective action for physicians who are unable to perform appropriately under selective preadmission review. 100% preadmission review means that every case in the category designated (i.e. carpal tunnel release, admissions for uncomplicated diabetes) will require preadmission review. This type of preadmission review will involve the physicain contacting a CFMC review coordinator who will screen the case using the pre-established criteria. If criteria for hospital admission are met, the coordinator can approve the admission. If criteria are not met the case will be referred to a CFMC physician advisor for review. All cases will, again be retrospectively reviewed to determine whether accurate information was provided during the preadmission review process.

Draft

COLORADO FOUNDATION FOR MEDICAL CARE

MEMORANDUM

#4

4-09-85

TO: JUDIE LENHART

FROM: BILL WOOD

!

SUBJECT: ADDITIONAL COSTS TO THE MEDICARE CONTRACT FOR 100% PRE ADMISSION REVIEW

The following is th estimate of the additional costs required to perform 100% Pre Admission review of all foot procedures, carpel tunnel's, cateracts, pacemakers, hernia repairs, DRG 42's and coronary bypasse's.

Estimated numbers are as follows:

Foot Procedure's = 600
Carpel Tunnel = 260
Cateracts = 5406
Pacemakers = 612
Hernia Repairs = 1466
DRG 42's = 387
Coronary Bypass = 571

TOTAL = 9302

The current workload for selective Pre-Admission has been running at approximately 100 per month or 1200 per year. Therefore, we are talking about an increase of approx. 8102 additional Pre Admission reviews.

At 15 min per review, this equates to an additional 2025 hrs of review time over what is currently being expended. Based on the average amount of work hrs available per year (1800), per FTE, this effort will require an additional 1.125 FTE coord. staff person to complete.Additionally there would be an additional clerical load for copying and mailing the approved forms or denial letters to the appropriate recipients.This effort is estimated at 10 min. per case.

Also,as part of this effort, all MOU's will have to be renegotiated with the hospitals and educational sessions will have to be rerun. The estimate for this effort is 16 hrs per hospital plus 1 hr travel time for management staff.

BUDGET ESTIMATE:

Mgt. Sal. = $27,168.00
Coord. Sal.= $19,288.00
Clerical = $ 6,235.00

Total Sal = $ 52,691.00
F/B's = $ 13,700.00
G & A = $ 27,154.00
Subtotal = $ 93,545.00

Physician Advisors:
Est. 1426 cases will go to PA for review @ 10 min. per review.
Est. PA costs = $ 11,883.00

Telephone Exp.:

Additional Telephone expenses are estimated at $ 15.000.00 to handle the increase in Pre Admission reviews.

Postage:

Additional postage is estimated at $ 7,130.00 to cover 4 mailings per case.

Data processing:

Data processing costs to cover the additional work load are estimated at $ 9,800.00

Travel:

Additional travel to support the renegotiation of MOU's, etc. is estimated at $ 1,000.00.

Per Diem:

Additional Per Diem to support the renegotiation of the MOU's is estimated at $ 700.00

The Total estimated cost or additional funds required over and above what is currently funded amounts too:

$ 139,058.00

cc: Hank Rael

#5

DEPARTMENT OF HEALTH & HUMAN SERVICES
Health Care Financing Administration

Region VIII
Federal Office Building
1961 Stout Street
Denver CO 80294

April 4, 1985

RECEIVED
APR 08 1985
CFMC EXEC. OFFICE

Mr. Arja P. Adair, Jr.
Senior Vice President
Colorado Foundation for Medical Care
6825 East Tennessee Avenue, Building 2,
Suite 400
Post Office Box 17300
Denver, Colorado 80217

Dear Mr. Adair:

In addition to the discussion we have had relative to the point that your preadmission review approach did not comply with HCFA contract requirements, I wrote to Dr. Zelinger on March 14 for HSQB reaction and guidance.

Dr. Zelinger telephoned me on March 28 to relate that the Colorado Foundation would have to abide by the contract and the specific guidance provided in the Peer Review Organization Manual, March 1985, (IM 2003.6) page 13 B., Preadmission Review, and page 17.

Thus, to enter into HCFA contract compliance, the Foundation must require the physician to receive permission from the Foundation on every preadmission case for hospital admission. Additionally, the Foundation must develop a process which will be incorporated into the PRO/FI MOU that parallels the requirement on page 13, IM-2003.6, which notifies the intermediary of cases requiring preadmission approval and annotation of or notice that the Foundation has approved the admission and the intermediary can pay the claim.

Obviously, my position is one of supporting the HCFA contract requirements, and I doubt if a contract modification would prove productive to the Foundation.

Please provide me with the necessary documentation validating compliance with the HCFA contract requirements by April 19.

Sincerely yours,

Tom Langan, Chief
Medical Review Branch
Division of Health Standards and Quality

#6

cfmc
COLORADO FOUNDATION FOR MEDICAL CARE

Building 2 Suite 400
6825 E Tennessee Avenue
P.O. Box 17300
Denver Colorado [illegible]
Telephone 303 321-6642

March 28, 1985

Mr. Tom Langan
Chief, PSRO Branch
Health Care Financing Administration
Region VIII
Federal Office Building
1961 Stout Street
Denver, Colorado 80294

Dear Mr. Langan:

The purpose of this letter is to respond to your correspondence of March 15 pertaining to the Foundation's application of preadmission review for its Medicare PRO Contract. As we both know, the spirit of the PRO law is to allow each hospital medical staff and hospital administration to assure the provision of appropriate acute care services to Medicare recipients. The PRO legislation and review system as designed by HCFA is intended to monitor medical staffs and hospital administrations and to deny when inappropriate care has been provided.

The response to the PRO proposal provided HCFA by the CFMC incorporates this philosophy within the preadmission review program. As noted in our proposal, Section III.B.19 through 27 as well as in Attachment A for the Amendments to the PRO Technical Proposal, Attachment F, Pages 1 and 2, the Colorado Foundation for Medical Care entered into contract with the Health Care Financing Administration to provide a selective preadmission review program. Specifically, this means that hospitals and medical staffs are provided the criteria by which an attending physician can evaluate the appropriateness of admission on a preadmission basis by reviewing the guidelines or criteria developed by the CFMC. In the instance that the attending physician or the hospital questions the appropriateness, the Foundation is available for a telephone preadmission review. Whether the attending physician decides to participate in the preadmission review or not, the Foundation data system is indentifying all cases for a retrospective review.

The retrospective review may result in a retrospective denial, a process which, in general, has been accepted by the Colorado medical community and the hospital community. Additionally, the CFMC's relationship with Blue Cross/Blue Shield, the fiscal intermediary, has been established along the same lines as selective preadmission with the hospitals. That is, Blue Cross/ Blue Shield has no problem in paying claims as they come in, recognizing that the CFMC on an ongoing basis will be retrospectively identifying claims for which payment may need to be recovered or withheld from the hospital account. We believe that the current system which is being run as proposed in the CFMC Technical Proposal and Amendments thereto provides for a valid working mechanism of assuring that Medicare only pays for medically necessary services. Further, we recognize that the implementation of 100% preadmission will require additional costs for both the Foundation and the fiscal intermediary in addition to putting an unneeded burden on professionally competent physicians and hospitals who are working well with the existing system.

Accordingly, we believe that Colorado should be allowed to maintain its existing preadmission review system without going to a 100% preadmission requirement. Please let me know if you need any further information or if we need to further discuss this issue in order to resolve any outstanding requirements.

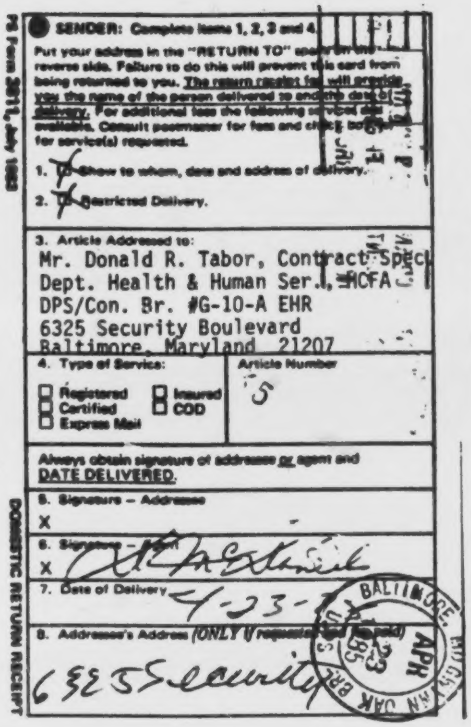
Sincerely,

Arja P. Adair Jr.

Arja P. Adair, Jr.
Senior Vice President

APA:ac✓

cc: Kenneth A. Platt, M.D.
    William J. Osheroff, M.D.
    Ms. Judie Lenhart
    Mr. Hank Rael
    Carl Boymel, Ph.D.



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3. Article Addressed to:

Mr. Donald R. Tabor, Contract Spec
Dept. Health & Human Ser., HCFA
DPS/Con. Br. #G-10-A EHR
6325 Security Boulevard
Baltimore, Maryland 21207

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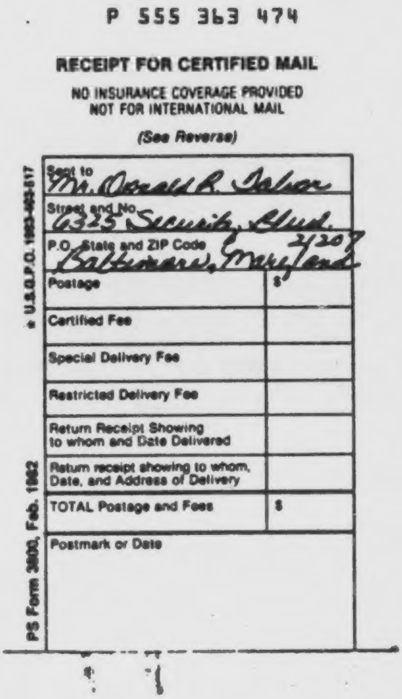

P 555 363 474

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☆ U.S.G.P.O. 1983-403-517

PS Form 3800, Feb. 1982

DEPARTMENT OF HEALTH & HUMAN SERVICES

[illegible]
Health Care Financing Administration

Region VIII
Federal Office Building
1961 Stout Street
Denver CO 80294

June 19, 1985

RECEIVED
JUN 2[illegible] 1985
CFMC EXECUTIVE OFFICE

Mr. Arja P. Adair, Jr.
Senior Vice President
Colorado Foundation for Medical Care
6825 East Tennessee Avenue, Building 2,
Suite 400
Post Office Box 17300
Denver, Colorado 80217

Dear Mr. Adair:

I apologize for the Government's delay in analyzing and providing the Colorado Foundation with comments on your letter of April 16 requesting a contract modification to perform 100 percent preadmission review.

I will limit my comments to my recommendation to HSQB, which I submitted on April 23, and a subsequent clarification provided to me this date on the status of the Foundation's request. I would anticipate that you should receive HCFA's official response within two weeks.

In my comments, I acknowledged the fact that HCFA signed the contract with the Colorado Foundation with a definition (submitted June 29) of selected preadmission review. However, the consensus, as I understand it, would be that the Foundation should have understood the meaning of preadmission review as defined in the RFP. In the original PRO proposal, there was not a clear understanding of what the Foundation meant by selective. I believe HSQB intends to elaborate on this area.

The substance of my recommendation went to the point that the Foundation was not required to perform 100 percent retrospective review, and could merely substitute that effort with 100 percent preadmission review, and return to the mandated 5 percent sample, which should be more cost effective for the Foundation.

I did recommend approval of the telephone costs and consideration of a part time R.N. to answer the telephone and complete the preadmission log at $10,000+. However, in my telephone discussion with HSQB, it was indicated that the Foundation justification required greater detail.

In summary, it is my understanding that the Colorado Foundation's request will be rejected by the program, but I have no evidence in written form.

Sincerely yours,

Tom Langan

Tom Langan, Chief
Medical Review Branch
Division of Health Standards and Quality

COLORADO FOUNDATION FOR MEDICAL CARE

ATTACHMENTS TO LETTER DATED JULY 10, 1985 TO MR. BILL TATE PERTAINING TO INTERIM MANUAL 85-2

1. Letter dated May 16, 1985 from Mr. Arja P. Adair, Jr. to Mr. Donald R. Tabor
2. Memorandum dated April 12, 1985 from Ms. Judie Lenhart and Ms. Joanna Rowe to Mr. Arja P. Adair, Jr.
3. Memorandum dated April 30, 1985 from Mr. Bill Wood to Mr. Hank Rael

file - pend for 6/10/85

cfmc
COLORADO FOUNDATION FOR MEDICAL CARE

Building 2 Suite 400
6825 E. Tennessee Avenue
P. O. Box 17300
Denver, Colorado 80217
Telephone: (303) 321-8642

May 16, 1985

Mr. Donald R. Tabor, Contract Specialist
Department of Health and Human Services
Health Care Financing Administration
DPS/Contract Branch, Room 6-10-A EHR
6325 Security Boulevard
Baltimore, Maryland 21207

Subject: Contract No. HCFA-500-84-0520 - No. 7
Cost Proposal to Implement Change in Scope of Work Directed by IM85-2
to Referenced Contract - Regarding Letter No. 6 dated April 16, 1985

Dear Mr. Tabor:

As reported to you in my letter dated April 3, 1985, the Foundation required time to evaluate the impact on our negotiated Scope of Work for the implementation of IM85-2. We submitted the impact on the Scope of Work and cost for preadmission on April 16, 1985. The purpose of this letter is to submit the results of our analysis on the remaining items affecting our Scope of Work and the cost impact.

Enclosed is the cost estimate to implement the changes to the Scope of Work, as outlined and directed by IM85-2, to the Colorado Foundation's PRO Fixed Price Contract. The major change in the Scope of Work, related to preadmission, and the additional cost to implement this major task was submitted to you in Letter No. 6 dated April 16, 1985. The total cost to implement the changes directed by IM85-02, including the $139,058 for preadmission, amounts to a net $220,840 for the period July 1, 1985 through July 30, 1986. This takes into consideration the reductions in workload such as 2050.1 - Intensified Review for $23,114.

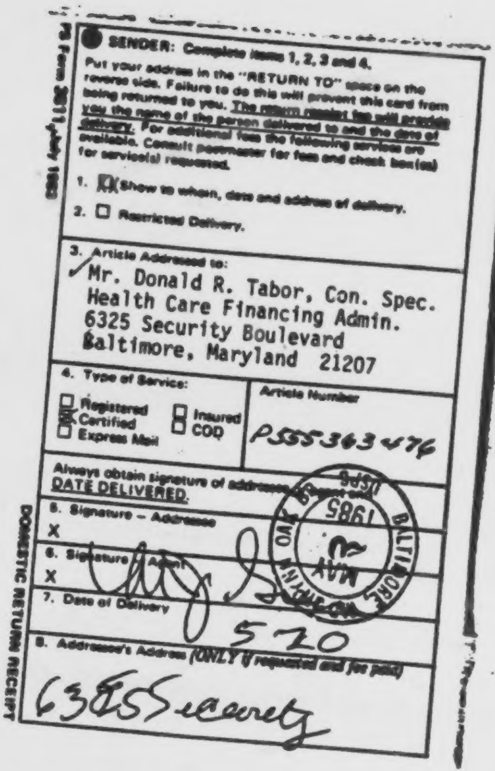
Accordingly, the Foundation requests Contract Officer approval for implementation and reimbursement of this additional Scope of Work which was not part of the negotiated contract entered into between the Colorado Foundation for Medical Care and the Department of Health and Human Services, Health Care Financing Administration effective August 1, 1984. We request your confirmation of these changes to the contract and an authorization for additional reimbursement given the additional work required in the implementation of Interim Manual 85-2. The Foundation intends to implement all provisions of these rquirements as of July 1, 1985, pending the Health Care Financing Administration's financial authorization.

Sincerely,

✓ Arja P. Adair Jr.

Arja P. Adair, Jr.
Executive Director

APA:eak
Attachment
cc: Kenneth A. Platt, M.D., Mr. Hank Rael, Mr. Tom Langan
bcc: William J. Osheroff, M.D., Ms. Judie Lenhart, Carl Boymel, Ph.D., Mr. Heinz Mueller and Mr. Andrew Webber



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Health Care Financing Admin.
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Baltimore, Maryland 21207

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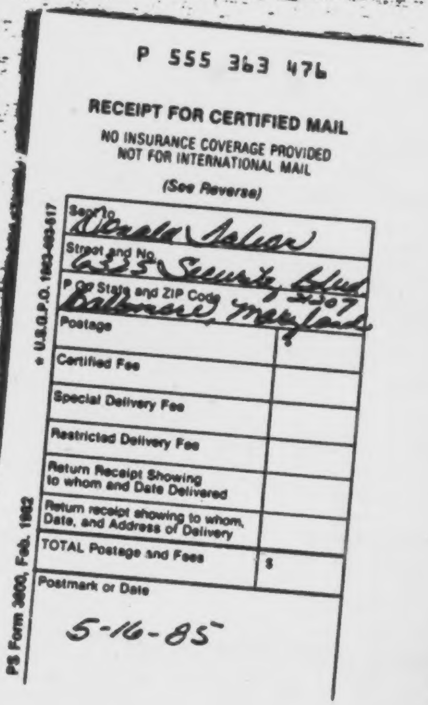

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5-16-85

PS Form 3800, Feb. 1982 ★ U.S.G.P.O. 1983-403-517

COLORADO FOUNDATION FOR MEDICAL CARE

MEMORANDUM

HAND DELIVERED TO MR. TOM LANGAN ON MAY 23, 1985 WHO TELECOPIED THIS MEMORANDUM TO MR. DON TABOR

TO: Arja P. Adair, Jr.,
Senior Vice President

FROM: Judie Lenhart
Director of Review Operations

Joanna Rowe
Manager of Review Programs

DATE: April 12, 1985

SUBJECT: Medicare Transmittal #IM 85-2: Projected Changes

The following changes and additions to the Medicare Review Program are deliniated in Transmittal #IM 85-2. Some of the changes and/or additions will not require an increase in work, but a few have the potential to be large increases. A list of the changes and/or additions with an estimated work requirement follows:

Page	Section	Change	Projected increase or decrease
6	2003	not copy Attending Physician on DRG Coding changes that he/she is not responsible for (procedure change)	0
8	2003.2	document beneficiary and facility receipt of preadmit notice (new requirement)	certified mail, 2 letters
9lb	2003.2	document attending physician response to predenial (new requirement)	0
11	2003.3	reopening initial denial determination to DRG Validation change (new procedure)	2.5% all DRG Validations
12	2003.4	notification of intensified review 20 days after end of quarter (new procedure)	0
15	2003.6	third party liability review (new procedure)	6 cases per quarter
16	2004	plan to HCFA for extension of review denial	0
18	2050	Noncovered Admissions with a Covered Level of Care (new procedure)	50 cases per year X 1= 50 hours per year

Arja P. Adair, Jr.
memorandum
April 12, 1985
page 2

Page	Section	Change	Projected increase or decrease
20	2050.1	Excluded Items and Services Review (new procedure)	?
20	2050.1	if 5% intensified review equals 5% of admissions do not have to do 5% admission sample review (procedure change)	less review
22	2005.1	transfers from PPS Hospital	0
28	2050.1	if readmits have 2.5% denial rate or 3, whichever greater, must review readmits even if not related (procedure change)	6 hospitals per quarter
30	2050.1	review code editors prepay (already do this change)	0
31	2050.2	Day Outlier (procedure change)	less review-50 per month
33	2050.2	Cost Review (new procedure and changes)	reduction from 150 per month to 75 reviews per month at 4-6 hours per review
37	2050.3	no warrenty information on pacemakers (procedure change)	0
39	2050.4	Physician Attestation statement (change procedure)	1 review per hospital per year=84 day= 672 hours
46	2050.4	Outpatient Services (procedure change)	0
47	2050.4	re-review of PRO DRG changes (procedural change)	40 per month, less appeals, pay 1 physician for less review
48	2050.4	notice of DRG sample	0
52	2050.4	review of DRG claim adjustments that adjust to a higher weighted DRG-100% review (new procedure)	*potential to be between 30,000 to 45,000 reviews per year
58	2060	noncovered changes	see page 18

Page	Section	Change	Projected increase or decrease
60	2070.1	Record of Review Activity and increase storage of records and logs (procedural change)	see Carl for data storage
61	2070.1	must keep denials for 6 years (procedural change)	increase storage for 2 years
sample selection		(procedural change)	see Carl-will be less reviews.

Please note that all projected changes are estimated as we do not have a firm grasp on these procedures and numbers since the majority of it rests upon the activity and performance of the hospitals and the Fiscal Intermediary. Please see us if you still have concerns or questions regarding our estimates.

Thank you.

JR/JL/crd

REPORT OF THE BOARD OF TRUSTEES

Report: R
(I-85)

Subject: AMA's DRG Monitoring Project and the Prospective Pricing System

Presented by: William S. Hotchkiss, M.D., Chairman

Referred to: Reference Committee G
(Ed L. Calhoon, M.D., Chairman)

At the 1984 Interim Meeting, the House of Delegates adopted Board of Trustees Report FF which contained early responses to the AMA's DRG Monitoring Project. Report FF outlined not only major physician concerns, but also contained an update on the Prospective Pricing System (PPS), and identified some of the Association's activities in this area.

The following report is intended to provide the House of Delegates with an updated discussion of the impact of the PPS based upon responses received by the DRG Monitoring Project through August 31, 1985. A summary of the current status and changes in the PPS are also included.

CURRENT STATUS OF THE PPS

Hospitals Affected

All hospitals which were expected to operate under PPS are now doing so. This represents a total of 5,405 or 81 percent of all hospitals participating in the Medicare program. The remaining 1,246 or approximately 19 percent of the hospitals participating in Medicare are exempted from the PPS. These include:

- 555 Short-stay hospitals in waivered states
- 464 Psychiatric hospitals
- 88 Long-term care hospitals
- 63 Rehabilitation hospitals
- 49 Children's hospitals
- 27 Alcohol/drug hospitals

In addition, 762 psychiatric units, 373 rehabilitation units and 314 alcohol/drug treatment units in acute care hospitals are currently exempted from the system.

Past House Action: I-84:154-161; A-84:342,344,348; I-83:200-201;
A-83:109-111,195-202,317-318;I-82:35-40,281;
A-80:178-181

Hospital Admissions

According to the August 1985 Health Care Financing Administration (HCFA) Background Paper, there were approximately 6.5 million Medicare short-stay hospital admissions from October 1, 1984 through April 30, 1985. This represents a decrease of 5.4 percent for the same period in fiscal year (FY) 1984.

The Professional Standards Review Organizations (PSROs) and the Peer Review Organizations (PROs) have continued to examine a percentage of Medicare hospital admissions and discharges. As of May 31, 1985, 32 percent of all PPS admissions have been reviewed, resulting in the denial of payment of 2.6 percent of the reviewed admissions. In FY 1984, 32 percent of all PPS admissions were also reviewed. Payment was denied for 2.8 percent of those reviewed admissions.

Length of Stay

From October 1, 1984, through April 30, 1985, the average length of stay (LOS) for Medicare patients in PPS short-stay hospitals was 7.7 days, which is slightly higher than the 7.6 days for the same period in FY 1984. The average LOS for Medicare patients in all short-stay hospitals, including exempted hospitals, was 9.0 days in FY 1984. In addition, HCFA notes that comparisons between FY 1984 and FY 1985 are difficult because of the geographic variation of PPS phase-in during FY 1984 and a lack of a complete year's worth of data in FY 1985.

Ten Most Common DRGs

Table 1 presents the ten most common diagnosis related groupings into which discharges have been classified through July 28, 1985, as reported by HCFA. These "top ten" DRGs have accounted for 29 percent of all PPS discharges during the current fiscal year. As can be noted in Table 1, there is a year-to-year fluctuation in DRG ranks. For example, while DRG 96 (Bronchitis and Asthma) moved from twelfth place in FY 1984 to sixth place in FY 1985, DRG 39 (Lens Procedures) dropped from third place in FY 1984 to eleventh place in FY 1985.

CHANGES IN THE PPS

HCFA has continued to receive recommendations for PPS modifications from the AMA and other health care organizations. Based on these recommendations and due to experiences with the system, HCFA was expected to implement the following changes, effective October 1, 1985.

Payment Rates

In analyzing the combined effect of the forecasted increase in the hospital market basket, the proposed composite factor, and the proposed composite policy target adjustment factor, HCFA concluded that the FY 1986 payment level should be 4.42% below the existing payment level. However, in its scheduled PPS rule change, HCFA will set the FY 1986 standardized payment rates at the same level as the FY 1985 payment rates.

Hospitals Affected

The states of Massachusetts and New York will not seek renewal of their waivers which currently exclude them from the Medicare PPS. Effective October 1, 1985, Massachusetts will be included in the PPS, as will New York, effective January 1, 1986.

TABLE 1
PROSPECTIVE PAYMENT SYSTEM MONITORING
TEN MOST COMMON DRGs
October 1, 1984 through July 28, 1985

FY85 Rank	FY84 Rank	DRG No.	Description	Discharges	Percent of Discharges
1	1	127	Heart Failure and Shock	210,720	5.2
2	6	089	Simple Pneumonia and Pleurisy	163,987	4.1
3	5	140	Angina Pectoris	134,623	3.3
4	2	182	Esophagitis, Gastroenteritis, Misc. Digestive Disorders	133,011	3.3
5	4	014	Specific Cerebrovascular Disorders	126,148	3.1
6	12	096	Bronchitis and Asthma	89,829	2.2
7	8	138	Cardiac Arrhythmia & Conduction Disorders	85,769	2.1
8	10	296	Nutritional and Misc. Metabolic Disorders	81,837	2.0
9	9	088	Chronic Obstructive Pulmonary Disease	74,910	1.9
10	7	243	Medical Back Problems	71,866	1.8

SOURCE: Health Care Financing Administration

DRG Reclassifications

HCFA was expected to implement the following DRG changes effective October 1, 1985:

- Bilateral Joint Procedures - In the first DRG Monitoring Project Report, the Board of Trustees reported that many physicians were concerned with inadequate reimbursement for bilateral knee and hip replacements which were classified under DRG 209 (Major Joint Procedures). HCFA has created

DRG 471 (Bilateral or Multiple Major Joint Procedures of the Lower Extremity) to encompass certain combinations of major joint procedures within DRG 209 that may be performed during the same hospital stay. Any bilateral knee and/or hip replacements that are performed during the same hospital stay will now be assigned to DRG 471. In general, payments for these procedures will be increased under DRG 471.

- Kidney Transplants for Diabetic Patients - Diabetic patients with end stage renal disease (ESRD) who receive kidney transplants are currently classified into DRG 468 (Unrelated O.R. Procedures). However, according to HCFA, since these patients required the clinical services and resources described for DRG 302 (Kidney Transplant), diabetic ERSD patients who receive kidney transplants will now be classified into DRG 302. In general, payments for kidney transplants will be increased under this reclassification.

- Alcohol and Drug Abuse DRGs - According to HCFA, the content and relative weights of DRGs 433-437 have been revised and recalibrated to accurately account for resources utilized in these DRGs. HCFA believes that these DRGs will provide a better means of distinguishing the cases in which substance abuse results in hospitalization and cases in which substance abuse requires both detoxification and rehabilitation care. The substance abuse cases will now be classified into the following DRGs:

  -DRG 433 - Substance Use and Substance Induced Organic Medical Disorders, Left Against Medical Advice.

  -DRG 434 - Substance Abuse, Intoxication, or Induced Mental Syndrome Except Dependence.

  -DRG 435 - Substance Dependence, Detoxification and/or other Symptomatic Treatment.

  -DRG 436 - Substance Dependence, Rehabilitation Therapy.

  -DRG 437 - Substance Dependence, Combined Rehabilitation and Detoxification Therapy.

At this time, any changes in payments under revised DRGs 433-437 cannot be estimated.

Recalibration of DRG Weights

The DRG relative weights currently used by the PPS are based on 1981 hospital operating cost information and data. For FY 1986, HCFA has recalibrated the DRG weights utilizing actual charge data set forth in the FY 1984 data set. Besides being more recent, this data was derived from 100 percent of FY 1984 Medicare hospital discharges, compared to the FY 1981 data which consisted of a 20 percent sample of Part A inpatient hospital bills.

In addition, many physicians have raised concerns that reimbursement payments are not adequate for cardiac pacemaker implantations (DRGs 115-118), intraocular lens procedures (DRG 39), and infective endocarditis (DRG 126). While HCFA has not selectively revised these DRGs, they have recalibrated the relative weights based on the FY 1984 data. Except for DRG 117, the relative weights for all the above DRGs will increase in FY 1986.

Outliers

The PPS has continued to authorize additional payments for atypical or "outlier" cases, which are defined as cases involving an unusually long length of stay (day outlier) or cases in which the costs are substantially above the DRG rate (cost outlier). Scheduled HCFA modifications for all DRGs include increasing the threshold for cost outliers from $13,000 to $13,500 and decreasing the length of stay outlier criteria from 22 to 17 days.

DRG MONITORING PROJECT

Purpose

The AMA's DRG Monitoring Project was designed as an information assessment activity to elicit reactions and comments from physicians on the impact of the PPS in their hospitals, and to identify "problem" areas that may necessitate further study. The information obtained from the project has been, and continues to be, instrumental in developing congressional testimony, formulating policy and seeking modifications in the PPS, and providing input into scientific studies.

Implementation

The DRG Monitoring Project was implemented in June 1984. During the past 16 months, the AMA has elicited physician responses through letters written to the chiefs of medical staffs in all U.S. hospitals on the PPS, and through advertisements in AM News and JAMA. Several state medical associations, national medical specialty societies, and hospital medical staffs have also promoted the project through their newsletters.

Status

As of August 31, 1985, 389 written responses representing approximately 7800 physicians have been received by the AMA. Comments were provided by physicians in 40 states, 20 different medical specialties, teaching and nonteaching institutions, and urban and rural areas. A majority of the responses were received from chiefs of medical staffs who incorporated the comments of their entire medical staffs. Several chiefs of staffs conducted their own surveys and forwarded the results to the DRG Monitoring Project.

The majority of responses presented views on several issues and a number contained detailed supporting documentation. The areas of most common concern were:

- Quality of care
- Costs of care
- Length of stay
- Admission/discharge policies
- Administrative relations

A summary of these categories is presented below.

Quality of Care

Of the comments received concerning quality of care, 66 percent stated that the quality had deteriorated, while 34 percent stated that the quality had either improved or remained the same.

One major concern encountered by many physicians involves hospital stays in which a second patient condition or complication also requires treatment. Some physicians reported that they have been discouraged from providing immediate treatment for a second condition, because the hospital may not receive additional reimbursement for a second procedure.

Some physicians also expressed concerns over the effect that early discharges may have on the health care of patients. Many physicians face the dilemma of either prolonging their patients' length of stay, or discharging them to alternative health care facilities. According to one respondent:

> "a number of patients we have had have been forced in a certain respect to go into (an alternative health care facility) from the hospital because they have not been able to go home yet and should have remained in the hospital, but could not because of marked overextension of their health care costs. I do feel some of these patients are receiving a lesser quality of care than other patients."

Another concern involved administrative "pressure" to place limitations on laboratory tests and procedures. Many physicians reported that quality of care may be affected by a decrease in the use of favorable influences by emphasizing preadmission testing and discharges to home care, others have questioned the quality of care when patients are discharged early to alternative health care facilities.

Administrative Relations

Of the letters received addressing administrative relations, 42 percent reported a deterioration in administration-physician relations, 30 percent reported no change, and 28 percent reported an improvement in relations. The negative comments related to administrative "pressures" to shorten LOS through early discharges; to delay treatment of secondary conditions or complications; to decrease the utilization of some laboratory tests; and to perform some procedures on an outpatient basis regardless of patient age and mobility. The positive comments related administrative efforts to develop medical education programs and literature on DRGs; to provide physicians with cost of treatment records comparing individual averages to medical staff averages; and to develop DRG committees comprised of physicians, administrators and ancillary hospital personnel.

Summary of Key Findings

The DRG Monitoring Project has continued to receive both positive and negative comments regarding the impact of the PPS on patients, hospitals and physicians. The areas which respondents identified as requiring further study include:

- The concern for deteriorating quality of care due to early discharges, limitations on laboratory tests, and hospital stays in which a second patient condition or complication requires treatment.
- The failure of DRGs to account for the severity of illness of individual patients.
- The continued financial risks faced by small and rural hospitals.
- The average LOS continues to be questioned for specific DRGs, such as traumatic stupor plus coma, surgery on cranial nerves, and nervous system neoplasms.

Positive comments have noted some instances in which costs have been cut and quality of care retained through the use of outpatient treatment, preadmission testing and discharges to home health care. Other comments have reported a positive effect that the PPS has had on improving communication between administrators and physicians.

laboratory tests necessary for proper diagnosis. In the words of one respondent:

> "Eventually the quality issue will focus on underutilization of the necessities of care by all providers (physicians and hospitals) versus the overutilization of the past."

Cost of Care

Of the comments received regarding the cost of care, 85 percent reported that reimbursement to their hospitals was inadequate for one or more DRGs. Fifteen percent of the comments stated that either the hospital has not lost money through DRG reimbursement, or the hospital was able to bring costs in line with reimbursement. Major areas of concern continue to be that: (1) severity of illness is not appropriately accounted for in DRGs; (2) small or rural hospitals are continuing to experience losses on DRGs; (3) bilateral hip and knee replacements have the same reimbursement as unilateral procedures; and (4) reimbursement is inadequate for cardiac pacemakers, lens procedures, and treatment for infective endocarditis.

Length of Stay

Of the comments received regarding length of stay (LOS), 65 percent of the respondents stated that LOS had decreased under the PPS, while 10 percent said that there had been no change in LOS. The remaining 25 percent of the respondents did not acknowledge a change in LOS, but questioned the appropriateness of LOS for certain DRGs. Some of these include:

- DRG 8 (Surgery on Cranial Nerves, over age 70 - mean LOS of 4.1 days)
- DRG 11 (Nervous System Neoplasms, under age 70 - mean LOS of 8.5 days)
- DRG 29 (Traumatic Stupor plus Coma, one-hour - mean LOS of 3.8 days)

Admission/Discharge Policies

Of the comments received concerning admission and discharge policies, 43 percent reported that there was pressure to discharge patients early, 32 percent stated that policies had changed for the better, and the remaining 25 percent stated that they have not noticed a change in hospital discharge policies.

The presumed reason behind early discharges involves keeping the LOS at the mean LOS for most DRGs, thus enabling the hospital to maintain "break even" reimbursement. While some physicians have reported

FUTURE ACTIVITIES BASED ON THE DRG MONITORING PROJECT

The DRG Monitoring Project will be an ongoing activity throughout the final year of the PPS phase-in. The Board of Trustees urges physicians to continue to report their experiences to the following address:

AMA's DRG Monitoring Project
Department of Health Care Resources
P.O. Box 10947
Chicago, Illinois 60610

The information will be used to:

- Identify the particular problem areas which have been, and will continue to be, forwarded to HCFA, utilized in congressional testimony, etc.
- Provide background information for a proposed joint AMA-Johns Hopkins University study of the long-term effects of the PPS on the quality of health care for Medicare beneficiaries.
- Aid in the continued development of policy initiatives and programs for physicians and patients.

The Board of Trustees will report to the House of Delegates on future DRG Monitoring Project findings.

DEPARTMENT OF HEALTH & HUMAN SERVICES

Health Care Financing
Administration

Regional Office VI
1200 Main Tower Building
Dallas, Texas 75202

September 6, 1985

Regional PRO Letter 85-16

Subject: Quality Review -Premature Discharge Cases

In the process of reviewing cases, PRO's should be alert to problems with quality of care, including premature discharges. Whether it results in readmission to the same or a different hospital or in no readmission at all, a premature discharge is an example of poor quality of care and must be addressed.

No matter what the basis for reviewing an individual case (i.e., admission sample, seven-day readmit, etc.) if the PRO reviewer believes the discharge to have been premature, he/she should refer the case to the appropriate area within the PRO for consideration of intensifying review of that hospital's admissions or developing a sanction action.

The same would be true of allegations of premature discharge which the HCFA Regional Office (RO) receives and forwards to PRO's for evaluation. The RO receives complaints about premature hospital discharges through Congressional offices, directly from beneficiaries, from fiscal intermediaries (through their review of home health and skilled nursing facility claims) and other sources. When the RO refers such a case to a PRO, the PRO should consider it as the basis for possible intensified review of a hospital or sanction action, depending on the PRO's analysis of the case. The RO may ask the PRO for feedback on individual cases, subject to the provisions of the confidentiality regulations.

During our quarterly reviews we will evaluate the action that each PRO has taken on premature discharge cases, both those that the PRO has identified and those the RO has referred.

Likewise, the Super-PRO will be examining sample cases for quality problems which the PRO may have failed to detect, utilizing generic criteria where individual PRO criteria may be lacking. In the interest of efficient performance of quality review you may wish to assure that quality criteria (including those for under-treatment and/or premature hospital discharge) are utilized in the review of all cases. PRO worksheets should document the outcome of quality review on each case.

If you have any questions, please call me at (214) 767-6301.

Ed Lessard

Ed Lessard, Chief
Medical Review Branch

DEPARTMENT OF HEALTH & HUMAN SERVICES

ADMINISTRATION
Division of Health Standards & Qualit

MEDICARE
MEDICAID 20th

Region I
John F. Kennedy Federal Bldg
Government Center
Boston MA 02203

RECEIVED
SEP 10 1985
HEATLH CARE REVIEW, INC.

September 6, 1985

Edward J. Lynch, Executive Vice President
Health Care Review, Inc.
The Weld Building
345 Blackstone Boulevard
Providence, Rhode Island 02906

Dear Mr. Lynch:

We are writing this letter in response to your request of August 8, 1985, regarding your ability, under existing confidentiality regulations, to cooperate with the Rhode Island Medical Society Committee that is interested in exchanging information regarding impaired physicians who are identified through the peer review process.

Disclosure regulations found at 476.105(b)(2) would seemingly allow for this disclosure, without notification to the practitioner of intent to disclose, when "imminent danger to individuals or the public health" exist. Our only concern is that we are uncertain as to the ability of the committee to meet our definition of a "licensing or certification body". As PROs are only allowed to disclose "in such cases and under such circumstances as the Secretary shall by regulations provide..." we have referred your question to our central office of HSQB and will share their interpretation as soon as we are informed.

Please contact Lin Parsons at (617) 223-5807 if you have any further questions prior to our relaying our final answer.

Sincerely yours,

Annette M. Kasabian
Chief, Medical Review Branch
Division of Health Standards
and Quality

AMPRA AMERICAN MEDICAL PEER REVIEW ASSOCIATION
440 FIRST STREET, N.W. • SUITE 510 • WASHINGTON, D.C. 20001 • (202) 628-1853

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Executive Vice President
Andrew Webber

September 6, 1985

C. McClain Haddow
Acting Administrator
Health Care Financing Administration
200 Independence Avenue, S.W., Room 314G
Washington, D.C. 20201

Dear Mr. Haddow:

On behalf of the American Medical Peer Review Association (AMPRA) and its member Peer Review Organizations (PROs), I am writing to express the growing concern of PROs that their contracted scope of work is being increased without formal modification of contracts and the opportunity to negotiate additional contract dollars. While many PROs have filed claims for increased payment under the "Changes" provision of their PRO contracts, they have not received responses from HCFA in a timely manner. Further, the responses to date have not been favorable. There has not been a single PRO that has received additional renumeration for documented evidence of increased work effort.

A sampling of instructions recently issued by the Health Standards and Quality Bureau which have increased the original scope of work include: Transmittal 85-2, where PROs are now required to issue technical denials, reopen denials to DRG changes, certify physician attestations, review every day of a hospital stay to determine if at any time during the hospital stay medical necessity exists; store medical records for an additional time period; a recent manual expanding readmission and transfer review; SUPERPRO guidelines.

While AMPRA recognizes the need for modification of existing contracts as we learn more about review under PPS, formal change orders and the opportunity for negotiation of additional dollars must accompany all new instruction to PROs. Further, whenever there is a change order the lead time for implementation must be mutually agreeable to all contracting parties. AMPRA seeks balance in federal contracting administration, recognizing the unique nature of physician peer review.

We thank you for your consideration of this issue and look forward to your reply. I am anxious to meet with you to discuss this situation, and to pursue other areas of mutual concern regarding physician peer review and the PRO program.

Sincerely,

Andrew Webber

Andrew Webber
Executive Vice President

cc: Phil Nathanson, Director of HSQB
    William Tate, PRO Contract Specialist

DEPARTMENT OF HEALTH & HUMAN SERVICES

MEDICARE MEDICAID 20

Memorandum

RECEIVED
SEP 16 1985
Rec'd............

Date September 9, 1985

Clarence J Boone

From Clarence J. Boone, Associate Regional Administrator
Division of Health Standards & Quality, Region IV

Subject Disclosure of PRO Data

To All PRO Contractors - Region IV

Attached for your information is an OGC opinion explaining what information PROs may disclose to Congressional staff.

If further information is required, please contact your project officer.

Attachment

DEPARTMENT OF HEALTH & HUMAN SERVICES
Office of the Secretary

Office of the General Counsel
Washington, D.C. 20201

HEALTH CARE FINANCING AND HUMAN
DEVELOPMENT SERVICES DIVISION

MEMORANDUM AUG 28 1985

TO : Philip Nathanson
Director
HSQB, HCFA

FROM : Robert P. Jaye R.P.J.
Deputy Assistant General Counsel

SUBJECT: Disclosure of PRO Data to Congressional Committee

You have asked whether you are legally authorized to respond positively to a request from congressional committee staff to release (or require a Peer Review Organization to release) patient-identifiable documents in the possession of the PRO. It is our conclusion that the statute and regulations preclude such disclosure. _/

Section 1160 of the Social Security Act forbids a Peer Review Organization from disclosing "any data or information acquired . . . in the exercise of its duties and functions. . . ." There are several exceptions listed. First, disclosure can occur "to the extent . . . necessary to carry out the purposes of" Title XI-B. Second, "in such cases and under such circumstances as the Secretary shall by regulations provide to assure adequate protection of the rights and interests of patients, health care practitioners, or providers of health care." Third, disclosure can occur to assist various federal and state agencies "recognized by the Secretary" as having responsibility for dealing with fraud and abuse, licensing and certification, and health planning. The regulations issued on April 17, 1985, allowed disclosure to the General Accounting Office, the investigatory arm of the Congress but not to any other legislative body. See, e.g., 42 C.F.R. §§476.106(b)(1), 476.139(a)(1)(iii), 476.140(b), (e).

_/ This memorandum does not address the situation which would exist if a duly authorized subpoena was issued for the information in question./The memorandum is restricted to discussing your authority and obligations in response to an oral or written request for the data. /

Since the statute expressly refers to regulations of the Secretary, those regulations have legislative effect, and are entitled to more than the usual deference by the courts. Needless to say, they are binding on HCFA and all of its officials and employees. In this connection, I would call your attention to the criminal provisions of §1160(c) of the Act for unauthorized disclosure.

Thus, it is our conclusion that disclosure of PRO information to a congressional committee, is not authorized, and is, indeed, prohibited. The mechanism specified in the regulations for Congress to obtain access to this information is to have the General Accounting Office make a request for it.

Jim
This piece leads
PRO's to believe that
any and all aspects
of the PRO program
are "confidential"!
"on penalty of fine or
imprisonment!"

DEPARTMENT OF HEALTH & HUMAN SERVICES

Memorandum

Date September 11, 1985

From: Associate Regional Administrator, Division of Health Standards and Quality
Health Care Financing Administration, Boston Regional Office

Subject: PRO Identification of Quality Issues

To: Director, Health Standards and Quality
Health Care Financing Administration, Baltimore

We are writing to request your assistance in responding to a PRO in Region I concerning the action HCFA anticipates from a PRO on identified quality issues.

While HCFA has expressed the position that PRO costs for resolving Quality problems are included in the current contracts, the relative performance (and workload) of PROs which have or have not identified Quality problems has caused us sufficient questions as to require your input.

As you will note from the attached, Health Care Review has identified a significant number of quality issues in Rhode Island and Maine. While the attachment reflect samples of 20 and 11 non-premature discharge quality problems, respectively, the PRO has reported 62 and 9 premature discharges and 13 transfers via the HCFA-516.

As you may recall from reviewing Regional Statistics, the following reflects the level of premature discharge Quality problems identified via the 516s for Region I PROs:

Via 516	Other
Connecticut	0
Maine	9
Massachusetts	0
New Hampshire	0
Rhode Island	62
Vermont	7

Assuming relatively comparable funding levels at all PROs, we have also reviewed the relative amount of required review and its workload impact for each Region I PRO. Our Summarized results are as follows:

	Denied Adm Review	Paid Under Waiver	Exempt Unit Transfer Denied	Paid Under Waiver	Referred to RO	
					Transfers	Premature Discharge
Conn.	3.3%	58%	19.55%	96%	4	0
Maine	5.92	11%	13.08%	0%	0	9
Mass.	2.61	0	0	0	0	0
N.H.	2.17	13%	0	0	0	0
R.I.	5.16	15%	5.69%	0	13	62
VT	1.51	5%	60%	0	0	7

Based on the above and other reports analysis, we have determined that all Region I PROs are performing the required amounts of review. However, as reflected above, the nature of their findings and the workload impact of such vary significantly.

Since there is no reason to believe that utilization or quality problems in one state are significantly different from another, we are uncertain as to how to interpret these data. At this point, we are unable to determine wheter some PROs are under performing, in light of the activities for which they have been funded, or another PRO is identifying a workload for itself beyond that it was funded to address.

May we have your comments on this matter so that we may respond to this inquiry.

Lawrence Osborn, M.D.

THE KANSAS FOUNDATION FOR MEDICAL CARE INC.
2951 S.W. Wanamaker Drive Topeka, Kansas 66614
Telephone: (913) 273-2552

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Topeka

Medical Director
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Manhattan

September 13, 1985

Ms. Brenda Burton
PRO Project Officer
Medical Review Branch
Health Standards and Quality Bureau
Health Care Financing Administration
Department of HHS, Region VII
Federal Office Building, Room 264
601 East 12th Street
Kansas City, Missouri 64106

RE: HCFA 500-84-0506
#0130

Dear Brenda:

The recent transmittal 85-5 concerning readmission and transfer review has raised an important question from the perspective of several Kansas hospitals. The question deals with skilled nursing level of care.

Under current regulations there is a requirement of a three day qualifying stay at an acute level of care prior to admission of a patient to a skilled nursing level of care allowing coverage by the Medicare program. In some instances the patient does not require an acute level of care but does require a skilled nursing level of care. If the PRO denies the acute hospitalization, therefore eliminating the three day qualifying stay, does this eliminate coverage by Medicare of the skilled nursing level of care?

A complication of this whole matter deals with the fact that the new regulations require a PRO to submit a sanction for a hospital that has three inappropriate transfers or readmissions within a calendar quarter. It can be interpreted that the admission to the acute facility was inappropriate and therefore the transfer to the skilled nursing facility was inappropriate and thus would require the PRO to sanction the facility that was involved in this type of activity.

Ms. Brenda Burton
September 13, 1985
Page 2

If our understanding of the above activities are interpreted as inappropriate transfers, then we believe that this interpretation destroys one of the objectives of the swing bed program and that is to provide smaller hospitals with an opportunity to provide needed skilled nursing level services. Potential jeopardy of a sanction caused by the qualifying stay of three days, which is considered to be medically unnecessary, will place the hospital at risk. This is a risk that most hospitals will not be willing to assume and will reduce the availability of needed skilled nursing level of care.

Your assistance in clarifying this matter will be greatly appreciated.

Sincerely yours,

Larry W. Pitman
Executive Director

de

1040B-70/71

Health Care Review Inc.

The Weld Building
345 Blackstone Boulevard
Providence, Rhode Island 02906
Tel (401) 331-6661

Quality Health
Care
1973

Edward J. Lynch
Executive Vice President

MAINE

QUALITY ISSUES PROTOCOL

APPROVED BY THE
BOARD OF DIRECTORS
OF HEALTH CARE REVIEW INC.
ON SEPTEMBER 17, 1985

MAINE PROTOCOL
QUALITY ISSUES

The Maine Quality Review Committee of Health Care Review Inc. has developed the following system for detecting, evaluation, and remedying quality of care problems not targeted by the five studies required by Health Care Financing Administration.

I. Recognition of possible quality of care issues : Information, data or details obtained from medical record review that may represent substandard care or other specific problems are obtained from several ongoing review mechanisms within the PRO. First, ongoing quality review studies conducted by the Quality Assurance department may illuminate some unsuspected problems. These problems may be supplemented by referred quality issues identified by nurses and physician advisors during the utilization review process. These problems may represent serious deficiencies in quality of care presenting an imminent danger to the health, safety or well-being of a patient or placing the patient in unnecessary high-risk situations. The problem may represent minor deficiencies in care including; services or items improperly or inappropriately provided, services which should have been provided but were not, complications which would not be expected as part of the natural disease process, etc. The problems may involve individual adverse events or patterns of substandard care.

II. Obligation of Sufficient Cause and Due Process: To uphold the standard of peer review and certify that all information or evidence on each case questioned will be correct, accurate and above reasonable doubt, all problems, incidents or adverse quality issues will be brought to the committee for initial assessment. All available documents or records customarily available will be provided for the committee in this review. The committee must first attest to the reasonableness and accuracy of the evidence provided before the case is documented as a problem and action is taken. For a specific case, should there be doubt or insufficient evidence, the committee may deligate a peer member of the committee to directly contact the attending physician involved for clarification or additional information.

III Review Mechanism

The committee will determine whether a quality of care deficiency is present, what level of deficiency is present and whether a physician or hospital should be held accountable. If the committee is unable to make this determination,the case will be referred to a physician reviewer, specializing in an area of medicine relevant to the problem.

If the committee and/or physician reviewer determines that the deficiency represents a violation of obligation, the attending physician and/or hospital will be notified in writing of Health Care Review Inc.'s identification of a preceived problem. The physician and/or hospital will be asked to respond within 30 days providing an explanation of the course of treatment delivered or additional relevant information. The physician will also be given an opportunity to discuss the case with the physician reviewer or committee representative.

The committee or physician reviewer may recommed that additional steps be taken prior to physician notification. This may involve data analysis or review of a sample of the practitioner's and/or hospital's medical records to allow conclusions regarding a possible pattern of substandard or inadequate care.

IV. INITIATION OF CORRECTIVE ACTION: The Health Care Review Inc. Quality Review Committee will take action on all physician responses. On the basis of additional information received from the physician and/or provider the committee will affirm, modify, or reverse the initial determination. The physician and/or the hospital will be informed in writing of the action taken as a result of additional information.

If the issue is not resolved to the committee's satisfaction then further action may be taken. Such action may involve directly contacting the physician, placing the provider or practitioner on focused review, or sanction proceedings. A recommendation for sanction of a provider or practitioner must be directed to the Secretary of Health and Human Services through the secretary's designee, the office of the Inspector General. The physician and/or hospital will be informed of the committee's conclusions, if sanction proceedings are recommended to the hospital administrator and/or physician will be given 30 days to submit additional material to the Office of the Inspector General.

V. INITIATION OF NOTIFICATION: Federal regulation specifies the respective functions required in sending specific initial notice to a physician under review. The definitions of violations and obligations are found within the regulations. Because of the latitude of definitions, a final quote from the Federal Register should set the policy for the committee.

A question to Health Care Financing Administration on the issue of violations, "before a PRO identifies a violation, the PRO should be required to speak with the practitioner or other person to obtain his or her view of the facts and to see if a matually satisfactory resolution could be reached."

Health Care Financing Administration's response, "A PRO must use all appropriate mechanisms of review and intervention to resolve adverse situations and assure compliance with the statutory obligations prior to using the sanction procedures specified in these final regulations. The sanction process is viewed as a measure of last resort in the peer review program. We believe that the broad scope of the basic responsibilities addressed in Sec. 474.34(a) applies to the requirement of resolving situations before using the sanction procedures under this final rule."

(Federal Register/Vol. 50, No. 74/Wednesday, April 17, 1985/
Rules and Regulations, page 15338, Sec. E)

9/17/85--Approved by the Board of Directors
of Health Care Review Inc.

Health Care Review Inc.

The Weld Building
345 Blackstone Boulevard
Providence, Rhode Island 02906
Tel. (401) 331-6661

Quality Health Care
1973

Edward J Lynch
Executive Vice President

RHODE ISLAND

QUALITY ISSUES PROTOCOL

APPROVED BY THE
BOARD OF DIRECTORS
OF HEALTH CARE REVIEW INC.
ON SEPTEMBER 17, 1985

HEALTH CARE REVIEW INC. QUALITY OF CARE ISSUES

RHODE ISLAND PROTOCOL

1. Identification of Quality Issues - Utilization review coordinators
   - Quality review coordinators
   - Utilization physician advisors
2. All cases referred to Quality Review Department
3. Quality review physician(1) determines severity of problem. Issue could be minor violation serious violation, or "gross and flagrant" or substantial violation.

Minor Violation	Serious Violation	Potentially Sanctionable cases
-Notice sent to physician and/or hospital	-Notice sent certified mail to physician and/ or hospital	-Issue must be reviewed by three physician If two of the three physicians determine issue is gross flagrant or substantial then:
-Physician and/or hospital given 30 days of receipt of notice to respond	-Based on response, Health Care Review Inc. will affirm, modify, or reverse its determination and will notify physician/or hospital	-Notice (certified mail) sent to physician and hospital emphasizing severity of the problems
-Based on response, Health Care Review Inc. will affirm, modify, or reverse its determination and will notify physician and/or hospital	-Health Care Review Inc. will recommend corrective action to physician and will monitor physician (and or hospital)	-Physician and/or hospital given 30 days to respond
-If physician does not respond a second notice will be sent certified mail, and hospital will be notified	-If monitoring detects further quality issues (3 or more cases) sanction proceedings will be initiated	-Bases on response Health Care Review Inc. will affirm, modify, or reverse its determination -If the issue is not resolved to Health Care Review Inc.'s satisfaction sancti proceedings may be initiated. The President, Medical Director, and Chair of the Quality Review Committee will screen potentially sanctionable cases, however, the Board will ultimately dec if a sanction is to be issued.

---

[1] Until a final protocol is established, Doctor Crisafulli and the Medical Director will conduct review of medical cases and Doctor Newhouse will conduct review of surgical cases.

RHODE ISLAND

QUALITY ISSUES PROTOCOL

Health Care Review Inc. is obligated, under the authority of the Health Care Financing Administration, to assure that the services provided to Medicare beneficiaries meet professionally recognized standards of health care. This obligation is fulfilled not only by specific quality review studies but also by acting upon quality of care problems detected routinely by utilization and quality review coordinators and physician reviewers.

The following protocol has been developed to correct situations as identified by Health Care Review Inc. nurse and physician reviewers where substandard care is being delivered.

Health Care Review Inc. and the Regional Office of Health Standards Quality Bureau, Health Care Financing Administration are currently exploring the possibility of forging a link with the Rhode Island Medical Society. This association would foster a collaborative effort to assure quality medical care for Medicare beneficiaries.

THE PRO's RESPONSIBILITY

Health Care Review Inc. is required as a PRO to review activities of practitioners and other persons who furnish or order health care services or items and, when warranted, make determinations that obligations were violated and that corrective action is needed. When a practitioner or other person fails to comply substantially with an obligation in a substantial number of cases, or violates an obligation in a gross and flagrant manner Health Care Review Inc. must report the violation to the Secretary of HHS. Substantial violation in a substantial number of cases means a pattern of care has been provided that is inappropriate, unnecessary or does not meet the recognized professional standards of care, or is not supported by the necessary documentation of care as required by the PRO. Gross and flagrant violation means a violation of an obligation has occured in one or more instances which causes a patient's death, presents an imminent danger to the health, safety or well being of a Medicare beneficiary, or places the beneficiary unnecessarily in high risk situations, or results in permanent loss of a major physical function.

Potential violation of obligations if confirmed by the office of the Inspector General, may lead to the "sanction process".

Violations which do not meet "substantial number" or gross and flagrant" criteria are considered to represent "lesser level violations" and must also be investigated by Health Care Review Inc.

RHODE ISLAND

QUALITY ISSUES PROTOCOL

Deficiencies in quality of care provided to a Medicare beneficiary may be ascribed to a practitioner or to a provider. Health Care Review Inc. nurse reviewers and physician advisors must be encouraged to be aware of quality of care problems, to be thorough in reviewing questions of the quality of care, and to refer cases to the Quality Review Department and committee in which there may be deviation from generally accepted professional standards of care.

The process for the referral of quality of care deficiencies and subsequent corrective action procedures are described below.

Problems in the quality of care may be identified by utilization review coordinators, quality review coordinators, or physician advisors.

If a physician advisor detects a potential quality issue during utilization review the issue should be documented and referred to the quality review department.

In situations where a utilization review coordinator perceives a quality problem and the case is being referred to a physician for utilization review, the physicain, if he/she choses, may also perform the quality review documenting his or her determination. The case must then be referred to the Quality Review Department. If the physician reviewer does not opt to perform quality review, the nurse coordinator will document the problem and refer the case to the Quality Review Department accompanied by the medical record.

All cases referred to the Quality Review Department and problem cased detected by quality review coordinators will be reviewed by physicians who have agreed to perform quality review.

Quality of care problems detected by utilization review coordinators but not referred to a physician advisor for utilization review will be documented and referred to the Quality Review Department.

Physicians on receiving the referral, will decide whether a quality of care deficiency is present and, if so, decide which level of deficiency is present and whether a physician and/or hospital should be held accountable.

If the deficiency represents a minor violation of obligation, the attending physician and/or hospital will be notified in writing of Health Care Review Inc.'s identification of the problem. The physician and/or hospital will be asked to respond within 30 days. The purpose of the notification is strictly educational.

Based on the physician's response, Health Care Review Inc. will affirm, modify, or reverse its decision. If no response is received, a second notice will be forwarded by certified mail to the physician and a copy will also be sent to the hospital.

If the violation is of a serious nature, the attending physician and hospital will be notified in writing of Health Care Review Inc.'s identification of the problem including the physician reviewer's rationale. This letter will be sent by certified mail. The physician and/or hospital will be given 30 days to respond and will be made aware of the consequences of not responding. On the basis of the additional information received, Health Care Review Inc. will affirm, modify, or reverse its determination. Health Care Review Inc. may recommend to the physician that some type of corrective action be taken. Subsequent monitoring will be performed as follow-up to this recommendation. If Health Care Review Inc. continues to identify problems (3 or more cases) then a sanction recommendation will be made.

If the physician reviewer determines that the issue represents a potentially "gross and flagrant" violation or a "substantial" violation then it must be reviewed by two other physicians. If two of the three physicians concur that the case falls into either of these categories then sanction proceedings will be initiated. A notice will be forwarded to the physician by certified mail, and hospital indicating the severity of the problem and requesting a response within 30 days of receipt of the notice. Health Care Review Inc., on the basis of the response, may affirm, modify, or reverse its determination. If the issue is not resolved to Health Care Review Inc.'s satisfaction Health Care Review Inc. must submit a sanction recommendation to the Office of Inspector General. The President, Medical Director, and Chairman of the Quality Review Committee will screen potentially sanctionable cases. The Board of Directors of Health Care Review Inc. will ultimately decide if sanction proceedings are in order.

This proposed protocol may be revised at any time if thought necessary by the President, Medical Director, Quality Review Committee Chairman, Quality Review Committee, or Executive Vice President.

9/17/85

DEPARTMENT OF HEALTH & HUMAN SERVICES

Health Care
Financing Administration

Region X
M/S 409
2901 Third Avenue
Seattle, WA 98121

September 18, 1985

The Honorable John Heinz
United States Senator
Chairman, Special Committee on Aging
United States Senate
Washington, D.C. 20510

Dear Senator Heinz:

This is in response to your August 30, 1985 letter, in which you requested copies of PRO correspondence to this Regional Office and our responses concerning Medicare quality of care issues and staff resources at the PRO and RO sites.

We have researched our files for the requested information, and have found no general inquiries have been received from the PROs on quality of care issues. We are onsite at our PRO locations each month, and quality of care issues have been discussed informally with the PROs during those onsite visits. Likewise, we have had telephone discussions with the PROs for RO guidance in specific quality of care cases.

We have received written information from the PROs on a small number of patient-specific cases. This patient-identifiable information is not being disclosed as we have been informed that the DHHS Office of General Counsel has ruled that we are prohibited from disclosing patient-identifiable medical case information.

In regard to the staff resources information request, enclosed are copies of the correspondence concerning the only PRO staff resources issue that has been addressed to us. In this case we believe that the lack of adequate review personnel at the subject PRO resulted not because of a lack of PRO monetary resources or Regional Office staff resources, but because the PRO simply resisted hiring the trained professionals it needed to meet its contract requirement. Since it has hired the needed staff in June 1985, its performance in DRG validation has vastly improved.

I hope I have been of assistance to you and your staff in your efforts.

Sincerely,

Thomas G. Wallner
Associate Regional Administrator
Division of Health Standards and Quality

Enclosure

Health Care Review Inc.

The Weld Building
345 Blackstone Boulevard
Providence, Rhode Island 02906
Tel (401) 331-6661

Quality Health Care
1973

Edward J. Lynch
Executive Vice President

September 19, 1985

Dear Doctor

As required by the Health Care Financing Administration, Health Care Review Inc. as the Professional Review Organization (PRO) in Rhode Island conducts medical review of Medicare beneficiaries to assure the medical necessity, appropriateness, and quality of that care.

Health Care Review Inc. is currently reviewing all readmissions within seven calendar days, and physician reviewers are making determinations as to whether premature discharge was involved in the first admission.

Premature discharge, which involves discharging a patient that is not medically stable or requires further treatment or testing, indicates substandard quality of care. Furthermore, in all cases of premature discharge, there is only one reimbursement for hospitalization for the same medical condition.

Enclosed you will find a Health Care Review Inc. Peer Review Documentation form for a premature discharge situation. The form contains the name of the patient, the admission in question, and the physician reviewer's rationale for the determination.

Before an actual denial is issued, you have the opportunity to comment on this case, discuss the rationale, or provide further information not documented in the medical record that might affect the actual determination. This must be accomplished by contacting the physician reviewer identified at the bottom of the rationale form before the date specified. A copy of this rationale is also being sent to the Chief Utilization Review Coordinator at your hospital.

Failure to contact the physician reviewer by the specified date will result in an initial denial determination which will be subject to the reconsideration process.

Since this case represents not only a utilization issue but also a quality of care issue, we strongly encourage your input if you disagree with the enclosed rationale.

Thank you for your attention to this matter.

Sincerely yours,

Frederick S. Crisafulli, M.D., F.C.A.P.
President

FSC:jh

cc: Utilization Review Committee

DEPARTMENT OF HEALTH AND HUMAN SERVICES

KS6

September 23, 1985

Larry Pitman
Executive Director
Kansas Foundation for Medical Care
2953 S.W. Wanamaker Drive
Topeka, Kansas 66614

Dear Mr. Pitman:

In your September 13, 1985 letter (#130) you inquired about the effect of Transmittal 85-5 on cases where an initial hospital stay denial is followed by a skilled nursing transfer.

IM 85-5 requires PROs to deny admissions when there is an attempt to circumvent PPS by premature discharge, inappropriate transfers or readmissions when one stay would suffice. This requirement does not affect your review of hospital admissions and a determination of medical necessity of that admission. The fact that a denied hospitalization directly affects coverage of skilled nursing care does not change the requirements of your transfer review. Once a transfer to a skilled unit is identified, you are required to review the appropriateness of that transfer. If the level of care required is higher or lower than a skilled level, the transfer should be denied. In those instances where a patient was prematurely discharged from a hospital (requiring higher level of care) you should count this transfer in relationship to the review requirements contained in IM 85-5.

An inappropriate hospital admission which is denied does not automatically make a subsequent skilled nursing transfer inappropriate. However, the fiscal intermediary will deem the skilled nursing care non-covered based on lack of a three-day qualifying stay.

Review requirements contained in IM 85-5 do not affect the claims where non-covered skilled nursing care results after a hospital denial by a PRO.

If you have further questions, please contact me.

Sincerely yours,

Brenda Burton, Project Officer
Medical Review Branch
Division of Health Standards and Quality

FILE
COPY

DHSQ:MRB:BBURTON:lr

Maine

Quality Review Problems Identified in Maine Are:

Identified Quality Problems	Action Taken
1. Hospital #39: Patient discharged three days post-op A/K amputation for gangrene foot no mention in path report of gangrene. Patient readmitted 24 hours later and expired.	Quality Review Action Pending.
2. Hospital #15: Inappropriate pre-op evaluation resulted in serious complication.	Quality Review Action Pending.
3. Hospital #39: Uncommon complication occurring to patient during surgical procedure.	Focused review being performed on physician involved.
4. Hospital #55: Patient expired; no code performed; no no-code order on chart.	Quality Review Action Pending.
5. Hospital #009: Question of unnecessary surgery post-op multiple post-op complications.	Case reviewed by quality committee, surgery found tobe necessary. Post-op complications were treated appropriately.
6. Hospital #62: Principal symptoms not dealt with; patient discharged; threatned harm to public.	Quality Review Action Pending.
7. Hospital #38: Patient diagnosed for possible malignancy, nothing done to R/O malignancy.	Case reviewed by quality review committee. Committee forwarded letter to attending physician identifying the problem and requesting additional information or explanation.
8. Hospital #66: Surgical misadventure (serious)	Case reviewed by quality committee. Committee determined case treated appropriately.
9. Hospital #34: Patient not treated for abnormal lab tests; discharged. Readmitted and died post-op after emergency surgery.	Case reviewed by quality committee. Committee forwarded a letter to physician involved identifying the problem and requesting additional information.

Continued....Page 2

Identified Quality Problems	Action Taken
10. Hospital #008: Physician did not deal with question of malignancy; patient ended up having radical surgery unnecessarily.	Quality Review Action Pending.
11. Hospital #008: Known malignancy; tumor never staged. No chemo radiation; required radical surgery.	Quality Review Action Pending.

MR/mas

9/25/85

Source: Quality Review
Department

MEDICARE MEDICAID NOTES

PREPARED BY THE OFFICE OF BENEFICIARY SERVICES FOR MEDICARE AND MEDICAID BENEFICIARIES

U.S. Department of Health and Human Services
Health Care Financing Administration

OCTOBER 1985

PEER REVIEW ORGANIZATIONS:

The Who, What, Where, And Why Of The "PROs"

It never fails. Just when you think you've finally digested Medicare's alphabet soup of acronyms, they come up with a new one. You've had your fill of HCFA, HMOs, CMPs, PPS, and DRGs and now . . . here come the PROs.

What Are PROs?

These PROs should not be confused with the ones who are butting heads on your television screen every Sunday afternoon. PRO stands for Peer Review Organization, and if you are a Medicare hospital patient, these PROs can be a lot more important to you than the gridiron variety.

Why Are They Called Peer Review Organizations?

They are not called Peer Review Organizations because they "peer" over your doctor's shoulder (although there's an element of truth to that interpretation). They are called Peer Review Organizations because they are made up of health care professionals (your doctor's peers; in some cases, maybe even your doctor). In other words, PROs are groups of practicing doctors and nurses who are paid by the Federal Government to review hospital treatment of Medicare patients.

Where Are These PROs?

There is one PRO for each State, the District of Columbia, and each U.S. territory. The names of the PROs, their addresses, and telephone numbers are shown at the end of this article.

What Do The PROs Do For Medicare?

For the time being, the Federal Government has asked the PROs to check three things:

1. Make sure that each Medicare patient receives all of the hospital care and only the hospital care that is medically necessary for his or her illness or injury.
2. Make sure that the care is provided in the appropriate place (that is, in the hospital or as an outpatient service).
3. Make sure that all of the services a Medicare patient receives meet generally accepted professional standards of quality.

How Do The PROs Check These Things?

The PROs are expected to accomplish these goals in a number of ways, including:

- Checking hospital admissions, re-admissions, and transfers to look for unnecessary or inappropriate care.
- Investigating complaints that Medicare patients are being discharged prematurely.
- Looking at hospital bills to see that they accurately reflect patient diagnoses and treatments.
- Checking to see that specific surgical procedures are performed only when medically necessary.
- Reviewing, prior to admission, the records of patients who are scheduled for "elective" or nonemergency surgery and deciding whether an inpatient hospital stay is medically necessary.

At the present time, PROs are reviewing the treatment of Medicare patients only in hospitals. In the future, they may be looking at the appropriateness and the quality of care given by other Medicare certified providers of care.

What Do PROs Do For Medicare Patients?

In addition to their overall responsibility for seeing that Medicare patients receive all of the hospital care and only the hospital care that is necessary for the treatment of their illness or injury, PROs also investigate individual patient complaints and respond to requests for review or reconsideration of decisions made on hospital stays.

If you feel that you have been refused admission to a hospital improperly or that you are being forced to leave the hospital too soon or that the quality of care you received was inadequate, you should first discuss this matter with your doctor or a hospital patient representative or discharge planner. However, if you are still unhappy with the care you are getting or the decision made on your hospital stay, you should contact the local Peer Review Organization.

How And When To Contact The PRO

If you are denied admission to a hospital, either by the hospital or the PRO, and you disagree with the decision, you can request a reconsideration. Your request should be submitted in writing within 60 days of the denial. You can send your request directly to the PRO or you can submit it through your local Social Security office (or Railroad Retirement office, if you are a railroad retiree). If you want your case to receive a priority review, your request should be submitted within 3 days of the original denial.

What If You Are Already In The Hospital?

If you are a patient in the hospital and you are notified that you must either leave the hospital or begin paying for the care yourself, Medicare has very specific rules about the form and content of such a notification, sometimes called a notice of noncoverage.

- This notice must be given to you in writing.
- This notice must be given to you at least 2 days before the hospital can begin charging you for the care.
- This notice must explain why you no longer need hospital care, and . . .
- It must explain how and where you can appeal the decision if you disagree with it.

You do not have to leave the hospital in order to request a PRO review of this notice of non-coverage, but you or a family member should make the request as soon as possible after you receive the notice. If you are still in the hospital when you make the request, the PRO has 3 working days to begin its review of the decision.

What If You Do Not Agree With The PRO's Decision?

If you disagree with the PRO's review decision, you can request a reconsideration. Further, if you disagree with the PRO's reconsideration decision and the amount of Medicare reimbursement in question is $200 or more, you can request a hearing by an Administrative Law Judge of the Social Security Administration. The request for such a hearing must be submitted in writing within 60 days of your receipt of the PRO's reconsideration decision.

Beyond the hearing level, you can take your case to court, if the amount in question is $1,000 or more. However, it is recommended that you obtain legal assistance before taking this step.

Where Are These PROs Again?

As promised, the names, addresses, and phone numbers of all the Peer Review Organizations are shown below:

Alabama
Alabama Quality Assurance
Foundation, Inc.
Suite 300
Twin Towers East
236 Goodwin Crest Drive
Birmingham, Alabama 35209
(205) 942-0785

Alaska
Professional Review
Organization for Washington
Suite 220
2150 North 107th Street
Seattle, Washington 98133
(206) 364-9700

American Samoa/Guam
Health Services Advisory
Group, Inc.
1020 East Missouri Road
P.O. Box 16731
Phoenix, Arizona 85014
(602) 279-1615

Arizona
Health Services Advisory
Group, Inc.
1020 East Missouri Road
P.O. Box 16731
Phoenix, Arizona 85014
(602) 279-1615

Arkansas
Arkansas Foundation for
Medical Care, Inc.
101 North 6th Street
Fort Smith, Arkansas 72902
(501) 785-2471

California
California Medical Review,
Inc.
Suite 402
1375 Sutter Street
San Francisco, California
94109
(415) 923-2000

Colorado
Colorado Foundation for
Medical Care
Building 2, Suite 400
6825 East Tennessee Avenue
Denver, Colorado 80217
(303) 321-8642

Connecticut
Connecticut Peer Review
Organization, Inc.
384 Pratt Street
Meriden, Connecticut 06450
(203) 237-2773

Delaware
Delaware Review
Organization
Suite 92-100
1601 Concord Pike
Wilmington, Delaware 19803
(302) 654-4488

District of Columbia
Delmarva Foundation for
Medical Care, Inc.
108 North Harrison Street
Easton, Maryland 21601
(301) 822-7223

Florida
Professional Foundation for
Health Care, Inc.
Suite 100
2907 Bay to Bay Boulevard
Tampa, Florida 33629
(813) 831-6273

Georgia
Georgia Medical Care
Foundation
Suite 400
1430 West Peachtree Street
Atlanta, Georgia 30309
(404) 881-5600

Hawaii
Health Services Advisory
Group, Inc.
Suite 1203
1441 Kapiolani Boulevard
Honolulu, Hawaii 96814
(808) 942-7784

Idaho
Idaho Medical Peer Review
Organization
1845 Federal Way
Box 7777
Boise, Idaho 83707
(208) 345-6727

Illinois
Crescent Counties Foundation
for Medical Care
Suite 240
350 Shuman Boulevard
P.O. Box 548
Naperville, Illinois 60540
(312) 347-8770

Indiana
Indiana Peer Review
Organization
Tower I
11550 North Meridian
Carmel, Indiana 46302
(608) 258-4680

Iowa
Iowa Foundation for
Medical Care
Suite 500
3737 Woodland Avenue
West Des Moines, Iowa 50265
(515) 223-2900

Kansas
The Kansas Foundation for
Medical Care, Inc.
2953 SW. Wanamaker Drive
Topeka, Kansas 66614
(913) 273-2552

Kentucky
Kentucky Peer Review
Organization
Suite 870
10101 Linn Station Road
Louisville, Kentucky 40223
(502) 426-4888

Louisiana
Louisiana Medical
Review Foundation
Suite 203
733 East Airport Avenue
Baton Rouge, Louisiana 70806
(504) 923-2078

Maine
Health Care Review, Inc.
(Rhode Island)
371 Fore Street
Portland, Maine 04101
(207) 879-0544

Maryland
Maryland Foundation for
Health Care
Suite 60, The Lafayette Building
40 West Chesapeake Avenue
Towson, Maryland 21204
(301) 337-7400

Michigan
Michigan Peer Review
Organization
40500 Ann Arbor Road
Plymouth, Michigan 48170
(313) 459-0900

Minnesota
Foundation for Health
Care Evaluation
Health Associations Center
Suite 300
2221 University Avenue, SE.
Minneapolis, Minnesota 55414
(612) 379-4443

Mississippi
Mississippi Foundation for
Medical Care, Inc.
P.O. Box 4665
1900 North West Street
Jackson, Mississippi 39216
(601) 948-8894

Missouri
Missouri Patient Care
Review Foundation
1026 C Northeast Drive
Jefferson City, Missouri 65101
(314) 634-4441

Montana
Montana-Wyoming Foundation for
Medical Care
P.O. Box 5117
21 North Main
Helena, Montana 59604
(406) 443-4020

Nebraska
Nebraska Foundation for
Medical Care, Inc.
Suite 800, CTU Building
1221 N Street
Lincoln, Nebraska 68508
(402) 474-4472

Nevada
Nevada Physicians Review
Organization
Suite 108, Building A
4600 Kietzke Lane
Reno, Nevada 89502
(702) 826-1996

New Hampshire
New Hampshire Foundation
for Medical Care
672 Central Avenue
P.O. Box 578
Dover, New Hampshire 03820
(603) 749-1641

New Jersey
Peer Review Organization
of New Jersey, Inc.
Jefferson Building East
330 Milltown Road
East Brunswick, New Jersey
08816
(201) 238-5570

New Mexico
New Mexico Medical
Review Association
2350 Alamo SE.
Albuquerque, New Mexico
87106
(505) 842-6236

New York
Empire State Medical,
Scientific and
Educational Foundation, Inc.
420 Lakeville Road
Lake Success, New York 11042
(516) 488-6100

North Carolina
Medical Review of
North Carolina, Inc.
Suite 200
1011 Schaub Drive
P.O. Box 37309
Raleigh, North Carolina 27627
(919) 851-2955

North Dakota
North Dakota Health Care
Review, Inc.
3415 Highway 83 North
Minot, North Dakota 58701
(701) 852-4231

Ohio
Peer Review Systems, Inc.
3720-J Olentangy River Road
Columbus, Ohio 43214
(614) 451-3600

Oklahoma
Oklahoma Foundation for
Peer Review
Suite 400
5801 Broadway Extension
Oklahoma City, Oklahoma 73118
(405) 840-2891

Oregon
Oregon Medical Professional
Review Organization (OMPRO)
Suite 300
1220 SW. Morrison
Portland, Oregon 97205
(503) 243-1151

Pennsylvania
Keystone Peer Review
Organization, Inc.
20 Erford Road
LeMoyne, Pennsylvania 17043
(717) 652-3229

Puerto Rico
Puerto Rico Foundation for
Medical Care
Suite 1520
Mercantile Plaza
Hato Rey, Puerto Rico 00918
(809) 753-6805

Rhode Island
Health Care Review, Inc.
The Weld Building
345 Blackstone Boulevard
Providence, Rhode Island 02906
(401) 331-6661

South Carolina
South Carolina Medical Care
Foundation
3210 Fernandina Road
P.O. Box 21667, Capital Station
Columbia, South Carolina 29221
(803) 798-0053

South Dakota
South Dakota State
Medical Association
608 West Avenue, North
Sioux Falls, South Dakota 57104
(605) 336-3505

Tennessee
Mid-South Foundation for
Medical Care
Suite 400
6401 Poplar Avenue
Memphis, Tennessee 38119
(901) 682-0381

Texas
Texas Medical Foundation
Suite 150E
7800 Shoal Creek
Austin, Texas 78757
(512) 459-3341

Utah
Utah Professional Standards
Review Organization
540 East 5th Street, South
Salt Lake City, Utah 84110
(801) 532-7545

Vermont
New Hampshire Foundation for
Medical Care
672 Central Avenue
P.O. Box 578
Dover, New Hampshire 03820
(603) 749-1641

Virginia
Medical Society of Virginia
Review Organization
Room 120
1904 Byrd Avenue
Richmond, Virginia 23230
(804) 289-5320

Virgin Islands
Virgin Islands Medical Institute
P.O. Box 1566, Christiansted
St. Croix, U.S. Virgin Islands 00820
(809) 778-6470

Washington
Professional Review Organization
for Washington
Suite 220
2150 N. 107th Street
Seattle, Washington 98133
(206) 364-9700

West Virginia
West Virginia Medical
Institute, Inc.
3412 Chesterfield
Avenue, SE.
Charleston, West Virginia
25304
(304) 925-0461

Wisconsin
Wisconsin Peer Review
Organization
330 East Lakeside Street
Madison, Wisconsin 53701
(608) 257-6791

Wyoming
Montana-Wyoming Foundation
for Medical Care
21 N. Main
P.O. Box 5117
Helena, Montana 59604
(406) 443-4020

* * * * *

MEDICARE/MEDICAID NOTES is prepared by the Health Care Financing Administration of the U.S. Department of Health and Human Services. Comments or questions should be mailed to:
MEDICARE/MEDICAID NOTES, Ronald J. Wylie, Acting Director, Office of Beneficiary Services, Health Care Financing Administration
6325 Security Boulevard, Baltimore, Md. 21207 (301) 594-8131

ALABAMA QUALITY ASSURANCE FOUNDATION
SUITE 300, TWIN TOWERS EAST
236 GOODWIN CREST DRIVE
BIRMINGHAM, ALABAMA 35209
TELEPHONE (205) 942-0785

STATE
PEER REVIEW
ORGANIZATION

October 11, 1985

Mr. Jim Michie
Special Committee On Aging
United States Senate
Room S-D-633
Washington, D. C. 20510

Dear Jim:

This letter is to provide to you additional comments on what transpired at the hearing of September 26, 1985. Please accept my apology for the delay in providing you these comments, but upon my return my desk was overflowing. To begin I would like to comment on the testimony of each of the three women who had had the bad experience with the Medicare health delivery system.

CAROL MAHLA:

1. While it appears Ms. Mahla's mother may have been prematurely discharged, her mother may have been properly scheduled for discharge to skilled level care in a nursing home.
2. It is very clear that the hospital did not follow established procedures to notify the patient concerning withdrawal of Medicare coverage. To do this properly the hospital would have to notify the patient in writing that after 48 hours if the patient remained in the hospital, the patient would be required to pay the bill. This notification could be given on the authority of the hospital's UR Committee if the attending physician agreed. If the attending physician did not agree to the discharge, then only the PRO could authorize the letter advising of the 48 hours to remain in the hospital under Medicare coverage. This letter, or course, should also indicate the patient's appeal rights.
3. The testimony indicates a strong case that quality skilled level care was not provided in the nursing home. As you know the Foundation has submitted two requests to HCFA to allow the PRO to conduct nursing home review. Nursing homes currently are required to do their own utilization and quality review under the supervision of the fiscal intermediary. As this case demonstrates, this self review for quality does not always work. Both of the Foundation's requests to do nursing home utilization and quality review have been denied by HCFA.

MARGARET M. BUTTRILL:

1. Here again, the hospital did not properly notify the patient concerning discharge from the hospital. DRGs are based on an average length of stay. Obviously, the hospital is able to keep the money when a patient is discharged before the average length of stay and is expected to keep patients and treat them with quality care when they encounter one that requires a stay beyond the average length of stay. This hospital appears to be taking the profit but using the DRG as a means to maximize the profit by not allowing the sick patients to stay the extra days they need for treatment. The proper procedures noted above for the hospital to put the patient on notice that Medicare coverage was to be withdrawn were not followed.

2. The same comments above apply to the care in the nursing home. Quality of care for Medicare patients in nursing homes is a matter of serious concern. What is difficult for me to understand is why the nursing homes continue to be allowed to do their own in-house review (I assume their costs are passed on to Medicare in the cost report) when most PROs could easily and at a relatively low cost control both the utilization and quality of care for Medicare patients in the skilled nursing facilities.

BETTY F. KRATT/DR. KARL K. KELLAWAN:

1. The transfer from the hospital to the nursing home on the authority of the hospital UR Committee over the objection of the attending physician Dr. Kellawan is improper. The patient should have remained in the hospital and only the PRO could authorize issuing the letter putting the patient on notice of 48 hours in the hospital remaining under Medicare coverage.

2. The confusion concerning the transfer from the hospital to the nursing home could probably be solved by the type of review and control of transfers to nursing homes proposed by the Foundation.

3. Dr. Kellawan's opinion that the DRG system causes a compromise in care per se is true only in those hospitals that treat the DRG length of stay as an absolute value rather than an average. The hospital can clearly maximize revenues by making a profit from the patients who are treated less than the DRG length of stay and prematurely discharging those patients who need more treatment time than the average length of stay. A further safeguard to the hospital who experiences a patient who does not respond to treatment is the fact that the hospital can request payment in addition to the DRG as a cost outlier.

> When the PRO approves the cost outlier payment the hospital gets both the DRG and the additional cost approved. The testimony makes it clear that some physicians and hospitals either do not understand the system or choose to ignore its additional elements in order to support their own points of view.

The only recommendation contained in the staff report to the Committee On Aging that I would like to see changed would be Recommendation 8. In my view that recommendation should be changed from a tracking recommendation to a recommendation that PROs can control the utilization (access to the nursing home) and review the quality of care in the nursing homes. Allowing PROs to approve transfers from the hospital to the nursing home would certainly address the problem of premature discharges. While premature discharges can also be addressed by in-hospital pre-discharge review, the only way to address the quality of care in the nursing home is to do a quality review on site in the nursing home.

Participation in the hearing was an interesting and enjoyable experience for both Dr. Sherrill and myself. Political considerations aside, Senator Heinz displayed a genuine concern and interest in the quality of care provided to the Medicare population under the Prospective Payment System (PPS). In my view, the PPS system is a valid approach in hospitals who take a reasonable and just view of the system and its relationship to the patients. Hospitals can provide good quality care and make a reasonable profit from the system. Hospitals who attempt to maximize profits at the expense of quality of care are the challenge that must be met by the PROs if we are to do our job successfully. I am confident that given the resources most PROs will be more than equal to the challenge.

Best Regards,
ALABAMA QUALITY ASSURANCE FOUNDATION, INC.

John W. Miller
Chief Executive Officer

:agw

Health Care Review Inc.

The Weld Building
345 Blackstone Boulevard
Providence, Rhode Island 02906
Tel. (401) 331-6661

Edward J Lynch
Executive Vice President

October 8, 1985

Dear Doctor:

It is my pleasure to inform you that the Board of Directors of Health Care Review Inc., the peer review organization for the Medicare program in Rhode Island, has determined that a case-by-case review of quality issues will be implemented. The purpose is to assure the continued high quality of medical care for Medicare beneficiaries in Rhode Island.

At the present time, all cases reviewed by Health Care Review Inc. staff and physicians for any purpose will also be assessed in terms of the quality of care being delivered to the Medicare population. You may receive a letter regarding a patient that you have treated. Our purpose is to interact with you to assure ourselves that only medically appropriate care is provided, and if medically inappropriate care is identified to prevent adverse situations from recurring in the future.

As you know, the PROs across the country have been involved in quality of care by focusing on five objectives mandated by the Health Care Financing Administration. Most knowledgeable physicians realize that this is not the most effective way of looking at quality of care or of identifying patterns of substandard care. In our judgement, the only way to adequately assess these quality issues is on a case-by-case basis, and deal with the patterns that emerge.

The PRO is required to take very specific steps if a pattern of serious issues develop or if a problem is considered to be "gross and flagrant" as defined by the Health Care Financing Administration. Under such circumstances, it may be necessary for the peer review organization to recommend sanctioning the physician and/or the hospital if no satisfactory intervention can be developed by Health Care Review Inc., the physician and the hospital.

Our intent is to identify patterns of substandard care and deal with these in a fashion such that reoccurrence is minimized.

I believe strongly that it is in the best interest of physicians to monitor themselves in this fashion to assure that only high quality medical care is delivered.

The rapidly changing regulatory atmosphere as indicated by the concerns of Congress regarding the provision of quality medical care to Medicare beneficiaries has shifted the focus from utilization to quality of care problems that may arise as a consequence of the Prospective Payment System (PPS) and the complete reversal of financial incentives for hospitals.

I am sure that we will be hearing more and more about quality issues and that we will be required to look at these issues more intensively and objectively in the future.

As physicians, we are the only ones who can do this job. I would welcome your participation in helping us achieve a functioning objective program. I would ask you for you to participate as a physician reviewer and I am enclosing an application form to be completed if you wish to so so.

Sincerely yours,

Frederick S. Crisafulli, M.D., F.A.C.P.
President

FSC:mas

Enclosure: Application Form

PLEASE PRINT

PHYSICIAN REVIEWERS/CONSULTANTS

NAME: (Last) (First) Middle (Initial) ______

ADDRESS: ______ TELEPHONE #: ______

R.I. LICENSE NUMBER: ______ YEAR LICENSED: ______

	BOARD CERTIFIED		/ ELIGIBLE	
SPECIALTY/SUBSPECIALTIES:	YES	NO	YES	NO
1. ______	☐	☐	☐	☐
2. ______	☐	☐	☐	☐
3. ______	☐	☐	☐	☐

ACTIVE HOSPITAL ADMITTING PRIVILEGES:

1. ______
2. ______
3. ______
4. ______

ARE YOU ACTIVELY ENGAGED IN THE PRACTICE OF MEDICINE/OR SURGERY?

☐ YES ☐ NO

AVAILABLITY FOR REVIEW:

1. BY PRIOR ARRANGEMENT ☐
2. IF POSSIBLE, LIST SPECIFIC TIME(S):

A. ______ C. ______

B. ______ D. ______

AVILABILITY FOR RECONSIDERATIONS:

1. BY PRIOR ARRANGEMENT ☐
2. IF POSSIBLE, LIST SPECIFIC TIME(S):

A. ______ C. ______

B. ______ D. ______

EDUCATIONAL BACKGROUND:

1. MEDICAL SCHOOL: ______________________________ YEAR GRADUATED: __________
2. INTERNSHIP: ____________________________________ YEAR'S: ____________________
3. RESIDENCY: _____________________________________ YEAR: ______________________

COMMENTS: ____

____

____

____

PEER REVIEW EXPERIENCE:

	PLEASE CHECK	
	YES	NO
- BOARD OF DIRECTORS	☐	☐
- PHYSICIAN ADVISOR	☐	☐
- UTILIZATION REVIEW COMMITTEE	☐	☐
- QUALITY COMMITTEE	☐	☐
- CRITERIA COMMITTEE	☐	☐
- PROFILE COMMITTEE	☐	☐
- ON HOSPITAL OR LONG TERM CARE UTILIZATION OR QUALITY ASSURANCE, OR MEDICAL EDUCATION COMMITTEE(S)	☐	☐
- OTHER PEER REVIEW EXPERIENCE	☐	☐

IF YES, PLACE: ____________________________
FUNCTION: ____________________________
YEARS: ____________________________

Please return to: Frederick S. Crisafulli, M.D., F.A.C.P.
President
Health Care Review Inc.
345 Blackstone Blvd.
The Weld Building
Providence, Rhode Island 02906

UAB
The University of Alabama at Birmingham
University of Alabama Hospitals/Medical Social Work Department
205/934-4737

October 16, 1985

Mr. Jim Michie
Special committee on Aging
U.S. Senate, Room SD-G33
Washington, D.C. 20510

Dear Mr. Michie:

As per our phone conversation on October 16, attached you will find the case studies requested.

Our understanding is that use of the case histories will be for the purpose of demonstrating the negative impact that the current reimbursement system is having on our patients and families.

It is our understanding that the case histories will be used without the identification of our institution, or our patients to protect their privacy.

Sincerely,

Erma Wesley/sw
Erma Wesley, ACSW

Tammy Pentecost
Tammy Pentecost, LCSW

EW/TP/sw

Attachment

619 South 19th Street / Birmingham, Alabama 35233
An Affirmative Action / Equal Opportunity Employer

Case #1

A 75 year old black male was admitted February 12, 1985, with no sponsorship. His admission diagnosis was congestive heart failure. The referral received was for assistance with nursing home placement.

The patient had been living with his daughter; however, she was unable to continue to care for him following discharge. The patient was financially eligible for Medicaid but was not medically eligible for nursing home placement. His family was not able to admit to a nursing home on a private pay basis. The social worker explored other community resources and the patient was discharged to a domicilliary on February 18, 1985.

Case #2

A 74 year old black female was admitted February 25, 1985, with Medicare sponsorship. Her admission diagnosis was COPD. A referral was received for nursing home placement.

The patient was ventilator dependent requiring skilled nursing care. The social worker contacted nursing homes in the area but none were accepting ventilator patients. The patient expired while the social worker was developing discharge plans.

Case #3

A 70 year old black male admitted February 25, 1985, with Medicaid. Admission diagnosis; pneumonia. Patient was admitted to the hospital from a nursing home. He had pulmonary problems and was ventilator dependent. Upon discharge he would require nursing home placement with a ventilator. The Social worker contacted three nursing homes and was informed that they could not take ventilator patients at this time. Patient expired while social worker was developing discharge plans.

Case #4

A 29 year old white male was admitted October 5, 1985, with both Medicare and Medicaid sponsorship. Admission diagnosis; Femur and Hip Dislocation. Referral for discharge planning - nursing home placement.

Upon receiving social service consult for discharge planning, on October 10, the social worker contacted the nursing home. The social worker was informed that the patient could not be transferred until Medicaid information had been received. Patient remained in hospital October 11 thru October 14 because the nursing homes would not accept patients on weekends.

In addition to the preceeding case histories there are other problems that social workers face when working on discharge plans. They are:

1. Patients requiring trachea care or suctioning are not taken by some nursing homes and limited by others. Must have reliable family support to care for them at home.

2. Patients frequently require equipment in a nursing home that isn't covered by Medicare in a nursing home, i.e. ventilator, O_2.

3. No nursing home vacancies.

4. Patients not meeting nursing home requirements but having no one to provide care in the home and unable to care for themselves.

5. Medicare insurance only way to pay the nursing home until the first of the month when Medicaid will pay.

asim
american society of internal medicine

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Executive Vice President
JOSEPH F BOYLE MD

Twenty-Ninth Annual Meeting
Washington DC
October 10-13 1985

REPRESENTING
internists and
All Subspecialists
of Internal Medicine

October 21, 1985

Honorable John Heinz
Chairman
Special Committee on Aging
Room G-33
Dirksen Senate Office Building
Washington, DC 20510

Dear Senator Heinz:

The American Society of Internal Medicine (ASIM), an organization representing more than 20,000 physicians who are specialists in internal medicine, would like to share with you the results of its survey of the effects of the prospective pricing system (PPS) on the quality of patient care. I also request that the survey be placed in the official record of the Aging Committee's hearings on quality of care and the Prospective Payment System.

The results of this ongoing survey of internists during the last 18 months show that physicians are clearly feeling pressure--both direct and indirect--to discharge Medicare patients more quickly, in some cases to the detriment of their patients' health. These findings corroborate the results of earlier studies by the General Accounting Office (GAO) as well as the Special Committee on Aging, which found, as you know, that patients are being discharged after shorter stays and in poorer health than before the implementation of the PPS system.

ASIM initiated the survey in March 1984 in an effort to evaluate the effects of the PPS system--both positively and negatively--on the quality of patient care. The attached results reflect the input of 246 ASIM members, representing broad-based internists, subspecialists of internal medicine and neurologists, who completed the survey as of mid-September 1985.

The Society plans to continue disseminating the survey as well as conduct a more scientific study of members in the near future. I look forward, Senator Heinz, to continued cooperation between ASIM and the Committee on this and other issues of mutual concern.

Sincerely,

T. Reginald Harris, MD

T. Reginald Harris, MD
President

TRH/srl
L-9163

1101 VERMONT AVENUE NW • SUITE 500 • WASHINGTON DC 20005-3547 • TELEPHONE (202) 289-1700

ASIM TODAY

The Impact of DRGs on Patient Care

A Survey by the
American Society of Internal Medicine
March 1984–October 1985

american society of internal medicine
1101 VERMONT AVENUE NW·SUITE 500
WASHINGTON, DC 20005-3547·(202) 289-1700

BACKGROUND

Following implementation of Medicare's prospective pricing system in 1983, ASIM initiated a number of activities designed to familiarize internists with this new payment mechanism and to assess its impact on patients and hospital/medical staff relationships. ASIM recognized that the provision of quality patient care would take on even greater importance under a prospective pricing system based on DRGs, and, consequently, in March 1984, authorized funds for the design and distribution of a survey to evaluate the effects of DRGs on patient care.

ASIM's survey on DRGs and patient care first appeared in the March 1984 issue of The Internist (see Attachment A). Since then, it has been offered to members through the Society's newsletter and distributed at component meetings on an ongoing basis. The primary purpose of the survey is to evaluate the effects of the PPS system--both positively and negatively--on the quality of patient care. Based on the responses received, ASIM will evaluate any trends that seem to be occurring nationwide and will communicate to Congress and the Health Care Financing Administration (HCFA) any changes that should be made to the DRG system (for example, recalibrating DRG weights or increasing the number of DRGs).

Although not a scientific survey, this project has successfully reached a substantial number of internists and elicited informative responses. As of mid-September 1985, 246 ASIM members, representing broad-based internists, subspecialists of internal medicine and neurologists, completed the survey. Many have submitted lengthy letters and case reports documenting specific instances where they believed DRGs had negatively affected patient care.

SURVEY RESULTS

The survey results are summarized below under five general areas: Quality of care, severity of illness, PRO review, changes in hospital practices/services, and hospital/medical staff relations.

1. Quality of Care

In its survey, ASIM asked internists whether they believed that the DRG system had improved the quality of care provided to Medicare patients (e.g., by encouraging more careful ordering of tests and procedures, initiating improved and utilization review programs, improved communication among hospital departments). Only 24 of the 246 respondents noticed an improvement in the quality of care provided to Medicare patients. Moreover, there were over 200 specific reports of incidents in which internists believed the quality of care had been compromised as a result of DRGs.

The most common of these, reported by 105 internists, was the premature discharge of patients due to perceived DRG-related, hospital-imposed pressures. The following comments from individual internists are illustrative of many of those received:

> "Printed forms appear on the chart 1-2 days before the DRG expires strongly suggesting discharge."

> "The overall thrust of communications from the (hospital) administration is towards early, perhaps inappropriate, discharge."

> "When the DRG 'expires' I am reminded and urged to do something."

> "Pressure to discharge sooner is very great and workup is often incomplete."

Many internists also reported receiving daily updates or notices on how much their hospitals were losing as a result of certain patients. There were also indications that these pressures are being communicated to patients. As one internist commented:

> "One local hospital details the cost on the front of the record--the patient is aware of this. It has created anxiety . . ."

The remarks of other internists imply that the pressure many of them are experiencing to discharge patients earlier may be more indirect:

> "The hospital is not exerting pressure on our staff, but there is pressure just knowing the hospital's livelihood depends on us."

Many internists gave specific examples of the types of patients they believed were being discharged earlier than medically appropriate:

> "Alzheimer's patients without good placement."

> "Patients with pneumonia and abdominal pains."

> "Stroke patients have been transferred to inadequate intermediate care facilities because they had the first bed available."

> "Patient with prolonged problems with deep vein thrombophlebitis. (Another) patient with pneumonia went home before completing antibiotic course. Both patients were readmitted."

> "A post-cholecystectomy patient age 82 who had a collapsed vertebra, could hardly walk, and was not eating properly."

> "I could give you at least 50 examples already. Most patients were in the cardiac and chronic obstructive pulmonary disease (COPD) classes."

In a related question, internists were asked whether there had been any increase in patient mortality or morbidity associated with premature discharges. Some 47 respondents agreed that in their opinion early discharges had led to increases in patient mortality or morbidity, with many offering their specific impressions and experiences:

> "I feel so, at least two medical fatalities might have been avoided."
>
> "One patient with leukemia died at home three days after a premature discharge."
>
> "Definitely. A patient did not meet the criteria for further stay. He died a few weeks later."
>
> "Increased morbidity but not mortality as yet, although expected in the future since the hospital will get stricter in its evaluation."

Internists were also asked whether they had experienced any pressure from their hospitals to discharge patients and readmit them within the next few days or weeks, or were aware of instances where this had occurred. Eighty-one internists complained about hospital pressure to readmit patients shortly after discharge. Subsequent readmissions have two implications regarding quality of care, as evidenced by the responses. First, many internists stated that a large portion of these readmissions were the result of premature discharges: the patients were not strong enough to leave the hospital and suffered relapses. A gastroenterologist recalled one such instance:

> "EM, a 70-year-old black female, was admitted to the hospital and discharged one week later. She had diabetes, cholelithiasis, weakness, and difficulty in taking care of herself. Additionally, arteriosclerotic heart disease was a problem. She was dizzy and also had peptic symptoms.
>
> On the last hospital day after she was seen on medical rounds, she decided not to have a cholecystectomy. The hospital called my office and said since she had made the decision, and since she was a 'DRG patient,' 'can she be discharged?' Under those conditions and in spite of the fact that I felt she needed medical supervision and several days more in the hospital for general care, regulation of diabetes, and further assessment regarding gall bladder and cardiovascular problems, I agreed to the hospital's request.
>
> This was a mistake. She was readmitted to the hospital some 12 hours later having had a 'black-out' spell at home, which probably represented a transient ischemic attack.
>
> It was probably my error in submitting to pressure to get the patient out of the hospital earlier."

Secondly, regarding complicated hospital stays, internists reported that hospitals have been encouraging them to discharge patients and to readmit them at a later date for treatment of a second condition they had diagnosed during the first stay. As several internists reported:

> "We're advised if patients are found to have multiple problems, handle one major problem per admission."

> "Patients with multiple medical problems have one problem primarily dealt with per admission."
>
> "We are made well aware of the 'rules' encouraging this."

One respondent described a case in which a patient with old pulmonary tuberculosis and supporative bronchitis was diagnosed as also needing cataract extraction. After the patient's course of IV antibiotics, the hospital wanted her discharged and readmitted for cataracts. Another respondent spoke of a similar case but with a more drastic end: the patient was discharged, and kept out of the hospital for one week in order to be readmitted under a new DRG; the patient then died during the second readmission.

Finally, internists were asked whether they'd experienced pressure to underutilize medically necessary tests and procedures, and if so, to cite specific tests and procedures that they believed were indicated given the patient's condition but were not provided, and any effect that underprovision of these tests and procedures may have had on patient mortality and morbidity. Only 35 out of a total of 246 internists responded affirmatively to this question. In fact, more internists (83) believe that DRGs have had the salutary effect of promoting a decrease in the ordering of unnecessary tests and procedures. However, a number of internists expressed concern that DRGs could eventually lead to underutilization of certain tests and procedures, to the detriment of patient care. In the words of one internist:

> "In my opinion, the single most important reason that 'unnecessary' tests are run is fear of lawsuits. When MDs can stop being afraid they will be sued if they miss some exotic, rare disease, they will stop ordering so many tests. I am afraid that the DRGs will pressure physicians to avoid tests because they aren't cost effective and legitimate diagnoses will be missed, leading to an increase in lawsuits. I think that one of the bad aspects of DRGs is that we cannot look for unusual disease entities because in general these searches are expensive and often nonproductive, and will be looked upon by PRO committees, etc., as inappropriate."

2. Severity of Illness

Internists were asked whether there were any DRGs they believed should be revised because they do not reflect the actual resources used to care for a patient or they do not account for variations that exist in the degrees of patient illness, given the same diagnosis. Almost half of the respondents (102) indicated that changes needed to be made to either some or all of the 468 DRGs to adequately reflect variations in severity of illness. As one member summed up:

> "I feel the biggest problem seen so far is that the DRG is unrealistic--patients often have several diseases which need evaluation and/or treatment but DRGs relate to only one diagnosis. That means either poor care or cost overruns."

Of the DRGs specifically mentioned as needing revision, these cases were repeated most frequently: Guillian-Barre's syndrome, respiratory failure, myocardial infarction (MI), cerebrovascular accident (CVA), leukemia, chronic obstructive pulmonary disease (COPD), and stroke. The major complaint against the code for respiratory failure was that it does not allow for variations in condition and response. The DRGs for MI, CVA, and COPD lack flexibility to account for outside variables and complications.

Physicians stressed the need for severity classifications as some cases require more hospital days than others. Respondents complained about the inadequacy of the DRG for leukemia to pay the cost of services as it underestimates the necessary amount of care. Internists commented specifically on such inaccuracy:

> "The length of stay allowed for acute leukemia hospitalization is less than ten days, yet a course of remission induction chemotherapy typically requires 25-35 days."

> "Continuous IV infusion for seven to ten days is standard for a diagnosis of acute leukemia (DRG 404), and the DRG allows nothing for this or usual complications."

The DRGs for strokes presented problems because all strokes are, as one internist phrased it, "lump(ed) into a few simplified categories;" variations and complexities of strokes are not accounted for.

Some 75 internists reported experiencing pressure from their hospitals to upgrade the severity of diagnoses in order to maximize reimbursement. Respondents stated that many hospitals educate physicians through lectures and posted reminders to, for example, "seek more proper categorization to obtain maximum payment." Others reported that:

> "(We're) told to list all possible diagnoses so the best ones can be chosen."

> "There are DRG lists on all floors. The medical records people are always 'negotiating' our discharge diagnoses with us."

> "Diagnosis terminology is changed to fit the computer program. No change in 'severity'."

> "If you want to stay with the hospital you probably have to do that since the hospital is a business and the administrators always look at dollar figures."

3. PRO Review

Approximately 56 respondents stated that they believed the hospital's designated medical review agent (PRO or in the absence of a PRO, a fiscal intermediary) had increased its denial of medically indicated admissions under DRGs, to the detriment of patient care. As several members commented:

> "Dependence upon criteria is too strict."

> "Borderline cases are turned down, but usually are revised on appeal--MDs are more careful. But what about the patient who needed care but is borderline, as is the elderly man with pneumonia who lives alone?"

> "I am sure that some patients are not admitted because of possible denial."

> "I've had two patients denied despite the fact they needed admission, in our first three months of DRGs."

Some 45 internists also indicated that the PRO or fiscal intermediary had denied care previously considered medically necessary under the cost-plus reimbursement system and therefore covered by Medicare.

4. Changes in Hospital Practices/Services

ASIM sought internists' views on whether the implementation of the DRG-based system has led to any decrease in the quality of services provided by hospitals such as (1) short staffing; (2) inappropriate substitution of nonbioequivalent generic drugs for brand name drugs; (3) a decision not to install a technologically advanced piece of equipment that has the potential to improve patient care; and (4) a decision not to treat certain types of illnesses, or encouragement of physicians to admit these patients elsewhere.

In response, 104 internists reported short staffing of, for example, nurses or lab technicians in their hospitals. They reported many lay-offs of nursing staff, resulting in increased paperwork and errors; decreased RN status and increased use of aides; decreased night coverage and delays in lab tests; and less nurses per patient. One internist reported not having "enough nurses to carry out tasks. A typical patient comment: 'I asked for a pain pill three hours ago."

Although not to as great an extent, ASIM members also noted the inappropriate substitution of non-bioequivalent generic drugs for brand name drugs (28 physicians); more decisions not to install a technologically advanced piece of equipment that has the potential to improve patient care (55); and decisions not to treat certain types of illnesses, or the encouragement of physicians to admit these patients elsewhere (43).

5. Hospital/Medical Staff Relations

A substantial number of internists spoke positively about hospital/medical staff relations. Three-quarters of the total number of respondents observed an increased awareness of medical costs among the staff. Some physicians commented that this consciousness of costs has heightened at the expense of quality care; for example, some argued that length of stay is shortened and the more costly and complicated tests are not implemented to the patient's disadvantage, or diagnosis/treatment of the more obscure illnesses is excluded. However, the general opinion is that this awareness is positive, as more physicians are becoming involved in various discussions and programs aimed at minimizing health care costs.

Forty-two respondents believed that the relations in general between the hospital and medical staff have improved. They've noticed increased participation and cooperation, and overall, better interaction between hospital and medical staff.

On the other hand, forty-two ASIM members complained about hospital efforts to identify and deny or restrict privileges to physicians perceived as "too costly." A more substantial number of respondents commented that although this has not been fully witnessed at this time, they can see such actions developing. Some have stated that the identification process--through so-called DRG profiles--has already begun, and that it is only a matter of time before outright denials are made by the hospital administration.

SUMMARY OF KEY FINDINGS

ASIM's survey results have documented both positive and negative experiences, opinions, and concerns of internists from across the country, and while anecdotal, provide some insight into the system's effects on physicians, patients and hospital/medical staff relations. As evidenced from the responses, many internists agree with the cost-saving potential of the prospective pricing system but are concerned that cost reductions will occur at the expense of patient care. Those responding to the survey clearly viewed pressures to discharge patients early as detrimental to the quality of patient care. This finding corroborated that of a study on DRGs conducted earlier this year by the General Accounting Office (GAO). The GAO found that patients are being discharged from hospitals after shorter lengths of stay and in poorer states of health than prior to DRGs. Many patients are being told improperly that they have to leave the hospital because their Medicare/DRG coverage has run out, according to the study.

Many internists responding to ASIM's survey recommended that adjustments be made to the DRG system so that it would better reflect variations in the costs of caring for certain patients. The average length of stay given in the Federal Register for each DRG was considered inappropriate for the following cases: Guillian-Barre's Syndrome, MI, CVA, COPD, leukemia, respiratory failure, and stroke.

FUTURE ASIM ACTIVITIES

ASIM will continue to survey members on an ongoing basis in an effort to evaluate the effects of DRGs on patient care. In addition to the ongoing survey, a more scientific survey will be conducted of a random sample of ASIM members. The Society will share these and future results with Congress, HHS, and PROPAC (Prospective Payment Assessment Commission), recommending changes to the system as appropriate.

The data received will enable ASIM to evaluate the system and propose any necessary changes. At this point, the Society has identified the major areas of concern and will continue further study in order to determine:

1. Whether or not the DRG-based system adversely affects the quality of medical care by limiting length of stay and results in the deterioration of the quality of hospital practices.

2. Whether or not DRGs decrease the accessibility of care by encouraging hospital review entities to deny certain admissions.

3. To what extent reimbursements are inadequate under the system and what the long term consequences are.

/srl
L-9001B

Total number of respondents--246

FOR INTERNISTS ONLY

Special Survey

ATTACHMENT A

How Have DRGs Affected Patient Care?

As all physicians know, a Medicare pricing system for hospital services based on diagnosis-related groups (DRGs) is now being implemented across the country, effective with the start of each hospital's fiscal year. This system is intended to encourage hospitals to become more cost efficient than has been the case in the past, and thereby to reduce the rate of increase in federal health expenditures.

ASIM is interested in collecting data with which to evaluate the effects of this system—both positively and negatively—on the quality of patient care. To do so, we need the help of internists—both ASIM members and nonmembers. If you are an internist or a subspecialist of internal medicine and have personally experienced any instances where the DRG system has affected the quality of inhospital care provided to Medicare beneficiaries, please complete the questionnaire below and return it to ASIM. To protect yourself and ASIM, please *do not* name or otherwise identify any patient; other physician; hospital, its management or personnel. Use generic terms only.

Based on the responses received, ASIM will evaluate any trends that seem to be occurring nationwide and will communicate to Congress and the Health Care Financing Administration any changes that should be made to the DRG system (for example, recalibrating DRG weights or increasing the number of DRGs).

There is no deadline for submission of this form since all hospitals are not yet under the DRG system; rather, we would like you to make copies, completing and mailing them to ASIM as the need arises. In addition, please feel free to make copies for other internists—ASIM members or nonmembers (e.g., in your practice or at hospitals).

Please answer the following questions based on your personal experience under DRGs, being as specific as possible in your response. Where appropriate, give examples of particular instances where the care of a patient has been affected, either positively or negatively. Including specific information related to each patient—age, sex, diagnosis, DRG assigned to the case, length of stay—would enhance the value of this questionnaire in establishing credible data with which to evaluate the DRG system. (Use additional sheets of paper as necessary.) PLEASE TYPE OR PRINT.

---

1. As a result of DRGs, have you experienced any pressure from your hospital to do any of the following—or been aware of instances where these problems have occurred (please check all those that apply):

☐ **Discharge patients earlier than medically appropriate. (Please explain specific circumstances.)**

105 responded affirmatively

☐ **If so, has there been any increase in patient mortality or morbidity associated with premature discharges? (Please explain.)**

47 responded affirmatively

☐ **Increase short-stay admissions. (Please explain.)**

48 responded affirmatively

☐ **Underutilize medically necessary tests and procedures. (Please cite specific tests and procedures that you believe were indicated given the patient's condition but were not provided, and any effect that underprovision of these tests and procedures may have had on patient mortality and morbidity.)**

35 responded affirmatively

☐ **Discharge patients and readmit them within the next few days or weeks. (Please explain.)**

81 responded affirmatively

☐ **Upgrade the severity of a diagnosis to maximize reimbursement (i.e., "DRG creep"). (Please explain.)**

75 responded affirmatively

☐ **Other. (Please explain.)**

35 responded

2. Are there any particular DRGs you believe should be revised because, for example, they do not reflect the actual resources used to care for a patient or they do not account for variations that exist in the degree of patient illness, given the same diagnosis? (Please explain, giving relevant DRG codes.)

102 responded affirmatively

3. Has the implementation of the DRG-based system led to any decrease in the quality of services provided by your hospitals such as:

☐ **Short-staffing (e.g., of nurses or lab technicians). (Please explain.)**

104 responded affirmatively

☐ **Inappropriate substitution of non-bioequivalent generic drugs for brand name drugs. (Please explain.)**

28 responded affirmatively

☐ Decision not to install a technologically advanced piece of equipment that has the potential to improve patient care. (Please explain.)

55 responded affirmatively

☐ Decision not to treat certain types of illnesses, or encouragement of physicians to admit these patients elsewhere. (Please explain.)

43 responded affirmatively

☐ Other. (Please explain.)

10 responded

4. Has the hospital's designated medical review entity (professional standards review organization (PSRO), peer review organization (PRO) or fiscal intermediary):

☐ Increased its denial of medically indicated admissions under DRGs, to the detriment of patient care? (Please explain.)

56 responded affirmatively

☐ Denied care previously considered medically necessary under the cost-plus reimbursement system and therefore covered by Medicare? (Please explain.)

45 responded affirmatively

☐ Other. (Please explain.)

13 responded

5. Do you think DRGs have led to:

☐ **Increased cost awareness on the part of the medical staff? (Please explain.)**

183 responded affirmatively

☐ **A decrease in the ordering of unnecessary tests and procedures? (Please explain.)**

83 responded affirmatively

☐ **Improved relations between the hospital and medical staff? (Please cite specific examples.)**

42 responded affirmatively

☐ **Efforts by the hospitals to identify and deny or restrict privileges to physicians perceived as "too costly?" (Please explain.)**

42 responded affirmatively

☐ Improved quality of care provided to Medicare patients (e.g., by encouraging more careful ordering of tests and procedures, initiating improved quality assurance and utilization review programs, improved communication among hospital departments, etc.)? (Please explain.)

24 responded affirmatively

Hospital Classification: ☐ Urban; ☐ Rural

Hospital Type: ☐ Community (nonprofit); ☐ Private (for profit); ☐ Teaching; ☐ Other (please specify) ________

Bed Size: ________

We have purposely left the responses anonymous to ensure greater candor in the replies. If you wish to identify yourself, however, please feel free to do so.

Internal Medicine Subspecialty (if any) ________

Date ________

PLEASE RETURN TO:

asim
american society of internal medicine
1101 Vermont Avenue NW Suite 500 Washington DC 20005

QUALITY
UTILIZATION
AQAF
APPROPRIATENESS
STATE
PEER REVIEW
ORGANIZATION

ALABAMA QUALITY ASSURANCE FOUNDATION
SUITE 300, TWIN TOWERS EAST
236 GOODWIN CREST DRIVE
BIRMINGHAM, ALABAMA 35209
TELEPHONE (205) 942-0785

October 24, 1985

Senator Jeremiah Denton
United States Senate
516 Hart Building
Washington, D.C. 20510

Dear Senator Denton:

Enclosed is a copy of a newpaper article that appeared in the Birmingham News last weekend. As you can see, the article provides hospital specific data (including death rates) for the hospitals in the Birmingham area. The Board of Directors at its meeting on Sunday, October 20, 1985, expressed concerns about data of this type being released from the HCFA Central Office. By HCFA Regulation, hospital specific data released by the PROs must first be sent to the hospitals for a thirty (30) day comment period and the hospital's comments incorporated into the release of information. While the newspaper reporter who obtained the information from HCFA did go to the hospitals concerned (after several discussions with local medical community representatives - myself included), his article did not convey to the reader the shortcomings of the HCFA data set as an indicator of quality of care. The DRG in the data set is based on the diagnosis which caused the admission. An admission for the surgical removal of hemorrhoids in which the patient died of a heart attack would be coded as DRG 157 with a disposition code of death which would make it appear to the casual observer of statistics that the hospital had a death following the Hemorrhoid operation (anal procedure).

Another concern is based on the mandate to protect physician and patient specific information and to insure that release of provider specific information does not provide implicit physician or patient identification. Uncontrolled release of hospital specific information by HCFA (who has no knowledge of the number of physicians in a hospital qualified to perform a specific procedure) will certainly make available implicit physician identification with the potential for malpractice suits based on a less than perfect data system. It is clear that if HCFA is to release uncontrolled hospital specific information that implicit specific physician identification will be possible in some instances.

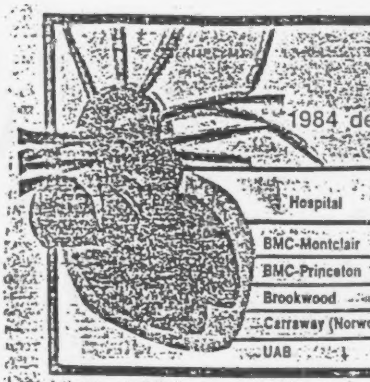
Another major concern voiced by the Board was the fact that most Medicare patients, upon reading the statistics in the table in the article, will be given the impression that the death rate at Carraway Methodist Hospital is an indication of the quality of care at that hospital. Once a table of this type is published, no amount of qualifying information in small print will off-set the impression to the Medicare recipient. Activities of this type lead to decisions based on mis-interpretation of information which could adversely impact the quality of care to a Medicare patient. For example, a hospital acting as a referral center for only those procedures which are high risk and are performed on patients with many other complicating factors, will have a much higher death rate (because of the risks involved) than a hospital who operates only on healthy patients with little or no complicating factors. The latter hospital will have the lowest death rate. A patient needing an operation who is in poor health would obviously be better served in the hospital whose physicians are experienced in dealing with high risk patients. However, the Medicare patient could easily be led to choose the hospital with the low death rate with the less experienced staff which would increase the patient's vunerability to an adverse outcome.

For these reasons the Board of Directors ask that HCFA follow the same guidelines for release of hospital specific information as PROs are required to follow. In the event that HCFA continues to release this type of information, some legislative relief should be sought in order to protect physicians and patients from implicit identification and Medicare beneficiaries from unexplained, often misleading, statistical information.

Sincerely,
ALABAMA QUALITY ASSURANCE FOUNDATION, INC.

Henry C. Mostellar, Jr., M.D.
President

Enclosure
:agw
cc: Sent To All Congressional Delegates



Coronary bypass:

1984 death rates and lengths of stay for Medicare patients in local hospitals*

Hospital	Cases	Deaths	Mortality rate	Average length of stay
BMC-Montclair	185	5	2.70%	14.76 days
BMC-Princeton	129	3	2.33%	15.37 days
Brookwood	151	3	1.99%	11.48 days
Carraway (Norwood)	104**	12**	11.54%**	16.70 days
UAB	390	14	3.59%	10.47 days

*Source: U.S. Health Care Financing Administration. Mortality rates were computed by *The News* using HCFA figures.

** These figures are based on U.S. Health Care Financing Administration records. Carraway Methodist Medical Center says the hospital's records show different figures and a lower mortality rate — 10.06 percent.

Public getting first look at some hospital records

In May, the federal government cracked open the door on hospital record rooms around the nation, deciding that for the first time the public would be allowed to see some of the information the government collects on the treatment of Medicare patients.

In the first days following the decision to open some records, *The Birmingham News* made requests for data on Medicare surgery patients at Birmingham area hospitals during 1984, the most recent complete year.

Through a Freedom of Information Act request, *The News* obtained from the U.S. Health Care Financing Administration, the agency that oversees Medicare, data on number and age of surgery patients, number of deaths, and average length of hospital stay.

HCFA officials said *The News* is the first paper in the country to get such data through the Freedom of Information Act.

The information also is available through state Peer Review Organizations (PROs) — which have been set up in each state to monitor the quality of care Medicare patients receive — but Alabama's PRO has yet to process the first request.

Among other things, sifting through the reams of Medicare statistics for Birmingham-area hospitals showed:

- Local hospitals had widely varying rates in mortality after coronary bypass surgery. One hospital's death rate was about three times that of any other hospital that did coronary bypasses; that hospital's officials said they believe they handle more difficult bypass cases than other hospitals.

See Records, Page 12A

Inside:

- **Length of hospital stay, 11A**
- **More on other surgeries, 12A**
- **Hospital medical records, 12A**

Death rates after heart surgery vary

By Bob Blalock
News health/science writer

Twelve of 104 Medicare patien who had coronary bypass surgery 1984 at Carraway Methodist Medic Center in Norwood died — a mortali rate about three times higher than th reported for Medicare bypass patien at any other Jefferson County hospit that year, according to federal figures

The figures were obtained from t federal Health Care Financing Adm istration.

Carraway officials said their ho pital records show a somewhat low death rate for Medicare corona bypass patients in 1984 than do the fe eral figures — 10.06 percent rath than 11.54.

See Heart, Page 12

Records

Heart

Common surgeries

HYSTERECTOMY

LENS

GALL BLADDER

HERNIA

STOMACH

PROSTATE

Officials say amount of data could increase

See Data, Page 13A

Several factors cited in range of stomach-surgery death rates

Data

■ From Page 12A

The group hopes to see more complex, complete data published, said Barbara Herzog, director of AARP's health care campaign. She envisions the local PROs publishing the data in a handbook.

"It should be a standard thing, updated every six months, which would boil down this information. It needs to be in some format other than some huge printout," she said.

Most local hospital officials said they have no problems with data on their hospitals being made available to the public for the first time.

"It's very healthy for all of us," said BMC-Princeton Administrator Byron Harrell. "It helps hold hospitals more accountable for what's happening."

Yet many people in the health care field questioned what the consumer can learn from the numbers and worried that consumers may jump to the wrong kind of conclusions.

First of all, the data is restricted just to Medicare patients, who unless they are disabled, are more than 65 years old. Lengths of stay and mortality rates generally will be higher for Medicare patients than other patients, local hospital officials said.

The officials also cited a lack of data for consumers to be able to make decisions about their hospitals.

"You have to have a whole lot more data than this," said Dennis Descher, administrator at South Highlands Hospital.

Dr. J. Durwood Bradley, chief of the medical/dental staffs at University Hospitals, said: "The variation in death rates and length of stays, I don't think it *per se* means one place is any better than another."

Most health care professionals question the data's lack of a rating to show whether a hospital sees sicker patients than other hospitals.

A. Keith Heartsill, chief financial officer at Shelby Medical Center, said because of the way Medicare reimburses — for the primary reason a patient was admitted to the hospital — a death may not necessarily have been due to that diagnosis.

There's also the possibility the patient died from a secondary infection — one caught while in the hospital — and the data doesn't show that either, said Michael A. Rooney, of People's Medical Society, a national health care consumer advocacy group based in Emmaus, Pa.

Dick Thompson, acting senior vice president for the Birmingham Regional Office of the hospital association, worried about how the public will view mortality rates.

"I feel the public will be jumping on those percentages, but until you look at the individual case and the complications that go with it, you can't tell much," he said.

Thompson said there is danger in reading too much into numbers that are often small for individual hospitals.

The data also does not show how many people were discharged from hospitals and sent home, where they may have died soon afterwards, Thompson said.

On the other hand, "The data does make everyone examine themselves," said Dr. William Leitner, vice president for medical affairs at St. Vincent's.

AQAF's Miller said the data now available should only make the consumer ask more questions. But patients should ask questions of their doctors, rather than hospitals, he said.

"The first question I would ask, is 'Do I really need that particular operation.' The second question I would ask would be, 'What are my chances of survival.'" Miller said.

Miller would also ask if the surgery would increase his life expectancy.

Rooney, director of projects for PMS, faulted the present data for being too simple.

"There's probably a lot more information that could be made public. Really usable data is still not being given to the consumer. What you have is a program that doesn't go far enough," he said.

"It's like you read in *Popular Mechanics* now, comparing Zebco fishing reels against Garcia fishing reels. That's going to happen, and that's a good thing," said BMC-Princeton's Harrell.

Said PMS' Rooney, "One of the biggest drawbacks is the fact it will not give information (on individual doctors). One of the reasons cited is that consumers would misinterpret the data. We think that is rather demeaning."

"If you see that a certain hospital has a mortality rate for appendectomy of 50 percent, you don't need five Ph.D.s to know something is wrong. But what you don't know is if it's Doctor A, B or C."

THE SECRETARY OF HEALTH AND HUMAN SERVICES
WASHINGTON, D.C. 20201

NOV 8 1985

The Honorable George Bush
President of the Senate
Washington, D.C. 20510

Dear Mr. President:

I am pleased to provide you with a report on the impact of the Medicare Hospital Prospective Payment System (PPS), which was requested by Section 603(a)(2)(A) of Public Law 98-21, the Social Security Amendments of 1983, which states:

> "The Secretary shall study and report annually to the Congress at the end of each year (beginning with 1984 and ending with 1987) on the impact, of the payment methodology under section 1886(d) of the Social Security Act during the previous year, on classes of hospitals, beneficiaries, and other payors for inpatient hospital services, and other providers, and, in particular, on the impact of computing DRG prospective payment rates by census division, rather than exclusively on a national basis. Each such report shall include such recommendations for such changes in legislation as the Secretary deems appropriate."

This first report in the annual series has been prepared at a cost of approximately $350,000. It is devoted largely to a description rather than a rigorous analysis of the PPS and its early impact, for several reasons. First, the data available for the analysis of PPS/non-PPS differences by hospital type were limited to bills received and processed by the Health Care Financing Administration (HCFA) through July 1984 for complete stays through June 1984. Second, the gradual implementation of the PPS makes it likely that its full effects will not be felt until future years, when prospective payment has been in place for a while and the affected groups have become more accustomed to its provisions and incentives. In addition, the dynamic nature of the health care sector serves to complicate any attempts to trace observed changes to any specific policy initiative.

However, the findings of this report do lead to several conclusions about the impact of the PPS in its first year. The new system appears to have been implemented smoothly, and to have encouraged substantial changes in the behavior of hospitals and of other major groups within the health care sector. More specifically:

- Impact on Classes of Hospitals--Average length of stay for Medicare patients has fallen, as expected, with the decline being the greatest in the history of the program. Contrary to expectations, Medicare admissions have also fallen. Whether these findings reflect the influence of PPS incentives, more stringent medical review, or a general trend toward decreased hospital utilization is unclear at this time.

  As expected, the Medicare case mix index appears to be higher at hospitals under the PPS. Transfers between short-stay hospitals also seem to be higher, as anticipated. The percentage of outlier cases and, consequently, the percentage of outlier payments are smaller than was initially projected. Also, there is some indication that medical education payments may represent a substantial source of additional revenue for teaching hospitals.

- Impact on Beneficiaries--A number of initiatives have been taken to monitor Medicare beneficiaries' access to health care and the quality of that care. Under the PPS, each hospital must contract with the Utilization and Quality Control Peer Review Organization (PRO) for its State or area, to review the reasonableness, medical necessity, quality, and appropriateness of health care services provided to Medicare beneficiaries.

  In addition to the PRO program, HCFA's survey and certification program is being revised to place more emphasis on outcome-oriented criteria in the Medicare conditions for participation. The potential of the Medicare swing-bed program for improving access to care under the PPS is currently being examined, and several other Federal, State, and private efforts are being made to monitor access and quality.

  Several intramural and extramural studies are being conducted and planned to evaluate the impact of the PPS on access and quality. The discussion in this report is restricted to the description and analysis of pre-PPS baseline data, because the results of these studies are not yet available. These results will be described in future reports.

- Impact on Other Payers for Inpatient Hospital Services--A number of State Medicaid programs have adopted prospective payment and/or DRG-based payment methodologies, but the Blue Cross and Blue Shield plans have tended to opt instead for alternative payment mechanisms such as health maintenance organizations and preferred provider organizations. Data are not available to describe the impact of the PPS on commercial insurers.

- Impact on Other Providers--There are some indications that physicians are being encouraged to change their patient management behavior due to prospective payment. In addition, discharge destination patterns appear to be changing under the PPS. Data from short-stay hospital bills show that the percentage of discharges to providers of post-hospital care is higher under the PPS.

Furthermore, the rate of growth of Medicare benefit payments appears to have decreased, led by the decline in inpatient hospital payments.

Thus, early evidence on the new system indicates that it is accomplishing many of its stated objectives, without any major problems thus far. For this reason, no recommendations for legislative changes are included in this report.

As the PPS continues to evolve over the next several years, and as additional data become available for analysis, upcoming annual reports will continue to focus on the issues described above. In addition, other issues specified by the Congress, such as the impact of computing DRG prospective payment rates by census division, rather than exclusively on a national basis, will be addressed in future reports.

Sincerely,

Margaret M. Heckler

Margaret M. Heckler
Secretary

Enclosure

DEPARTMENT OF HEALTH & HUMAN SERVICES

Health Care
Financing Administration

Memorandum

Date NOV 19 1985

From Director
Office of Medical Review, HSQB

Subject HCFA's Policy Regarding Factors to be Considered by PROs in Making Admission Determinations

To Associate Regional Administrators
Division of Health Standards and Quality
Regions I - X

The purpose of this memorandum is to clarify HCFA's policy with regard to the demographic, social, and cultural factors which PROs may consider relevant to admission determinations.

Factors which may result in an inconvenience to a patient or family do not, of themselves, justify hospital admission. Where such factors affect the patient's health, the PRO will consider them in determining whether inpatient hospitalization is appropriate. PROs approve Medicare payment for hospital care only when they determine that a less costly setting (e.g., outpatient, nursing home, home care setting) would not be equally effective in providing needed care, or would pose a direct threat to the safety or health of the patient. For example, the PRO may determine that hospital inpatient care rather than outpatient care is required only if the patient's medical condition, safety or health would be significantly and directly threatened if the care was provided in the less costly setting. Without accompanying medical conditions, factors that may cause the patient or family inconvenience in terms of time and money needed to care for the patient at home, or travel to the doctor's office, or which may cause the patient to worry, do not justify a patient's admission to a hospital or justify a PRO's approval of a higher level of care for a patient.

We expect the policy outlined above to be reflected in each PRO's explicit screening criteria as soon as practicable. This policy must also be communicated in writing to all PRO physician reviewers in order that they may understand our position. Please send copies of your notification to the PROs to me by close of business November 29.

RECEIVED
NOV 22 '85
HCFA[DHSQ]SCOB, REGION VII

DEPARTMENT OF HEALTH & HUMAN SERVICES

Office of Inspector General

Memorandum

Date NOV 25 1985

From Richard P. Kusserow
Inspector General

Subject Early Alert: Inappropriate Discharges and Transfers Under the Medicare Prospective Payment System (PPS) - Information Memorandum

To C. McClain Haddow
Acting Administrator
Health Care Financing Administration

The purpose of this memorandum is to alert you to the preliminary findings of our inspection concerning inappropriate discharges and transfers under PPS.

The Office of Analysis and Inspections is conducting a study of the 4,724 cases of suspected inappropriate discharges and transfers referred to the HCFA Regional Offices by the various medical review entities during the period of October 1, 1983 through May 31, 1985. The objectives of our review are to:

1. determine the number of documented cases of inappropriate discharge or transfer during this period;
2. categorize the cases and document their disposition;
3. review the appropriateness of corrective actions taken by HCFA or the PROs on any potentially gross and flagrant instance of substandard care; and
4. examine the existing procedures pertaining to the identification and disposition of these cases.

The early findings of our inspection have disclosed serious deficiencies in the procedures used by the PROs and HCFA concerning the analysis and resolution of cases of inappropriate discharges and transfers. Specifically we are deeply concerned that:

1. We are unable to find supporting documentation on a large number of the reported cases.
2. We have found numerous cases of substandard care in which there was little or no action by the PROs.

3. We have grouped the referred cases by provider and have identified patterns of potential violations by a number of providers. In the vast majority of cases these patterns have escaped identification by PROs and consequently little or no effective corrective action has been taken.

Based on our preliminary findings we are deeply troubled at the ineffectiveness of the existing procedures used by PROs to review cases of substandard care. We believe that it is imperative that HCFA take strong action to place more emphasis on PRO responsibilities for analyzing raw data and taking corrective action where there are patterns of poor quality of care.

We will continue to develop information related to serious quality of care violations and to patterns of less serious violations committed by certain physicians and providers. In a number of cases we will forward our information back to the PROs for more development.

We will keep you informed of our findings as our work continues. We are prepared to meet with your staff to discuss our findings. Contact can be made with Barry Steeley on FTS 472-5343 to arrange a meeting.

DEPARTMENT OF HEALTH & HUMAN SERVICES

Health Care
Financing Administration

Memorandum

Date 11/26/85

From C. McClain Haddow
Acting Administrator C. McClain Haddow

Subject Inappropriate Discharges and Transfers Under the Medicare Prospective Payment System (Your Information Memorandum of November 25)

To Richard P. Kusserow
Inspector General

We are quite surprised by the conclusions in the subject information memorandum.

First, we certainly share your concern that PROs become more active with respect to assuring the quality of care provided to Medicare beneficiaries. Our commitment to this is reflected in the modifications we have proposed to the PRO Scope of Work, which include application of generic quality screens to all cases under review and increased attention to patient status at the time of hospital discharge. Further, we will gladly accept your offer of further staff discussion of your findings. I must pass along to you, however, my strong disagreement with your "preliminary conclusions", and my puzzlement over them.

- Although your memorandum states you are studying 4,724 cases, in fact you actually reviewed slightly less than 3700. Of these cases, many predated PROs and were reviewed by PSROs or fiscal intermediaries, neither of which had "clout" to deal with quality issues. These cases are not appropriate for discussions about how well PROs are doing their jobs.

- Of the cases you reviewed that were actually handled by PROs, all but a handful predated the effective date of the PRO sanction regulations (May 17, 1985) which first provided the PROs with real authority to deal with serious quality problems, and all of them predated the release of the "premature discharge" instructions (cleared by the Office of General Counsel on July 25, 1985) which first gave the PROs authority to deny payment on at least some readmissions because of inappropriate prior care. Thus, the IG study limited itself to cases handled by PROs before they had all the tools they now have to deal with quality problems. It is simply incorrect to assume that PROs are handling cases now the way they did during the period of the study.

- Most disturbing of all, our respective staffs met on October 16, 1985 for the purpose of discussing the preliminary findings referred to in your memorandum. At no time during that meeting were any of the findings characterized as "disclosing serious deficiencies", or being "deeply troubling" by IG participants. In fact, there was no indication of major problems.

[✓ IG] ✓
DIG ✓
AIG-A
AIG-AI ✓
AIG-I
EXEC OFC
PM
OGC/IG ✓
EX SEC ✓
DATE SENT 11/29

'85 NOV 26 AM 10 25

* U.S. GOVERNMENT PRINTING OFFICE 1982-527-060/5182

In the implementation of complex new programs like PRO, it is not reasonable to expect that all possible problems will be anticipated, or that snags and delays in implementation will not occur. It is reasonable, however, to expect us to identify problems, fix them, and learn from experience to strengthen overall program administration. We believe we have done this with the PROs. We would certainly be interested in any positive suggestions you might have to improve our quality review procedures as they now stand, or to improve the quality activities for PROs laid out in the second Scope of Work.

JOHN HEINZ, PENNSYLVANIA, CHAIRMAN

WILLIAM S. COHEN, MAINE
LARRY PRESSLER, SOUTH DAKOTA
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STEPHEN R. McCONNELL, STAFF DIRECTOR
DIANE LIFSEY, MINORITY STAFF DIRECTOR

United States Senate
SPECIAL COMMITTEE ON AGING
WASHINGTON, DC 20510

November 14, 1985

Eleanor Chemlinsky
Director, Program Evaluation and
Methodology Division
U.S. General Accounting Office
Washington, D.C. 20548

Dear Ms. Chemlinsky:

Thank you very much for your cooperation and testimony at the Senate Special Committee on Aging's November 12th hearing on Medicare's prospective payment system. Your testimony provided valuable information concerning HCFA's quality assessment activities. I know that I speak for the whole Committee in commending you for a most clear and interesting presentation.

As I indicated to you at the hearing, there is a set of questions to which I would like you to respond relating to your testimony and to that of Mr. Haddow. I also know that you have several points which you wanted to make for the record, and I encourage you to submit those and the answers to the questions below as soon as possible. Also, for your information, I have enclosed a copy of the 1984 Annual Report to Congress on the impact of the Medicare hospital prospective payment system, which the Committee received under subpoena from the Department of Health and Human Services. Your comments on the report or any aspect of Mr. Haddow's testimony relating to the GAO's review of HCFA activities would be most appreciated.

On pages 12 and 13 of Mr. Haddow's prepared testimony to the Committee, he said that HCFA is looking at the impact of PPS on patient care through five separate quality of care evaluations. I would like you to comment on each of the five evaluations in respect to two issues: (1) Will the study provide statistically valid and reliable information on whether PPS is producing changes in quality of care for patients in the acute and post-acute settings? (2) Will the study provide statistically valid and reliable information on whether PPS is producing changes in access to care for patients in the acute and post-acute settings?

Thank you again for your cooperation and assistance. I look forward to receiving your response.

Sincerely,

John Heinz

JOHN HEINZ
Chairman

Enclosure

M.D., F.A.C.P.

INTERNAL MEDICINE
ENDOCRINOLOGY - METABOLIC DISEASES

November 27, 1985

The Honorable John Heinz
Chairman, Special Committee on Aging
Senate Office Building
Washington, D.C. 20510

Dear Senator Heinz:

Enclosed you will find a copy of a note that says it "all".

There is only so much that one can take in medicine and still keep a sense of loyalty and honesty in regard to medical practice. There is also a point at which one can "lose it". I will make this as short as possible because this is a good example of what transpires at the level of the hospital on a day in and day out basis.

Appended to this on the 'front index sheet' which is the legal discharge sheet for the business office, Medicare and third party payers, was the final diagnoses in a sequential order. In addition the reviewer for the record room and DRG Committee, who is a physician himself, noted that this patient, in addition to heart failure, cardiac arrhythmia, possible stroke and multiple medical problems, had also had a podiatrist see him in order to clip his toenails and improve upon his ingrown toenails.

In essence, what it is saying as outlined in red is: Please ask Dr. H who is the podiatrist, to add toenail debridement under operations and procedures. It increases payment markedly. He will be down to add them. I think the initials are those of a Dr. C who is a "reviewer" for the record room and the DRG Committee. He is a "paid killer". Obviously he has to find things like this to justify his position in order to get his income which is in turn paid by the hospital.

In essence what it states is: Just by adding the fact that the man had his toenails clipped, the income for the hospital according to the DRG payment system is increased from $3,175.00 to $6417.00! All I can tell you is that's a hell of an increase to have your toenails clipped! As the record custodian told me in the record room on Thanksgiving, the day I was signing the charts, "It pays big bucks for ingrown toenail excisions."

I need not say more; I think you understand what I am saying. I am not benefitting from this - the hospital is. Why aren't you and the committees looking at the hospitals for this type of manipulation, etc. that generates income that really is not there so that they may propagate themselves, have more administrators, more vice-pres., more committee members, etc. Once they have more, they will find more things on the chart to code and to generate income in order to perpetuate themselves as it were in the form of a malignancy. The cancer does not exist with doctors; the cancer exists with this type of reporting system. This is not an isolated phenomenon and I cannot attest to the fact that it happens at all other hospitals, but I am sure it does and somehow it has to be stopped because we as physicians are getting sick and tired of the accusations being laid upon us that we are responsible for the increased cost of care and fees paid out via Medicare.

Please believe that this is a true fact and, if you so desire, I would be delighted to have the entire chart photographed for you to review. I would be delighted to discuss it with you or a member of your committee and I would be delighted to reappear if necessary since there is only so much a physician can take from the moral and professional point of view before he stands up to be counted.

I hope this point is clear and whether he had his toenails clipped or not wouldn't have made one iota of change in the treatment pattern or in his longevity and quality of life, but it certainly enriched the hospital to the tune of $3000.00 plus.

Very truly yours,

Sig R. Greenberg MD FACP

Sigmund R. Greenberg, M.D., F.A.C.P.
Chairman, Department of Endocrinology
Abington Memorial Hospital

Associate Professor of Medicine
Temple University Medical School

cc: o.c.
cc: Mr. Michie
cc: Mr. Schulke

Sent to
B. David [illegible]

CASE - Benjamin T
admitted 11/4/85 to 11/13/85
Medical record #
373120F

Please ask Dr H
to add Toenail debridement
under operations & procedures —
~~[illegible]~~
It ↑'es payment markedly.
He will be down to add this —
Thank you

Nov 28, 1985

ask Podiatry dept to
add to Front index sheet
ie: will ↑ DRG payment
from $ 3175— to $ 6417—

(Quote = "it pays Big bucks" for Ingrown
toe nail excision !!!)
record room custodian

Signatory
? Att
* reviewer
record Room
& DRG
committee

DEPARTMENT OF HEALTH & HUMAN SERVICES

Health Care
Financing Administration

Memorandum

Date NOV 2 9 1985

From Director
Office of Medical Review, HSQB

Subject Clarification of Denial Notice Content and Effective Date of IM 85-5

To Associate Regional Administrators
Division of Health Standards and Quality
Regions I-X

The purpose of this memorandum is to clarify the content of the denial notice to providers, practitioners, and beneficiaries required by PRO Manual Transmittal 5, and the effective date for implementation of the transmittal. We are continuing to review a number of additional questions concerning the subject transmittal and will issue further clarification or revised instructions as appropriate.

For denials resulting from the application of Section 3015.A of the PRO Manual, the PRO is to issue detailed letters to providers and/or practitioners describing why the particular admission is being denied (i.e., the basis for the denial). For beneficiaries, the denial notice should not provide the detailed rationale for the decision, but should simply state that the beneficiary is not liable to pay the cost, however, Medicare is denying payment because the hospital circumvented the prospective payment system. The notice should include beneficiary indemnification language, as well as reconsideration procedures.

Should the beneficiary request a reconsideration, the reconsideration notice should indicate that the case was denied because the hospital circumvented the prospective payment system. This is also true when the provider requests a reconsideration, and the beneficiary is a party to the reconsideration (i.e., the reconsideration notice to the beneficiary should be general and nondescriptive).

The denial requirements in Sections 3010.A, 3010.C and 3010.D of the PRO Manual concern quality of care actions prohibited by law since 1983. Therefore, these denials are effective with PRO reviews conducted on or after July 25, 1985. For cases denied as utilization problems under Section 3010.B (e.g., admission for work-up following a few days at home and a subsequent admission for surgery), the effective date is with admissions after September 3, 1985 which is after receipt by the hospitals of Hospital Manual Transmittal 457 notifying them of these procedures.

Please disseminate this information to all PROs in your area. For any questions related to this memorandum, contact Michael Rappaport at (FTS) 934-3980.

Joseph J. Hladky

DRAFT

INSPECTION OF

INAPPROPRIATE DISCHARGES AND TRANSFERS

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Lead Region:	January, 1986
Chicago	Control Number: P-05-86-0050

Support Regions:
New York
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MAJOR FINDINGS

- Based on the findings of this inspection, it is apparent that occurrences of premature discharges and inappropriate transfers do exist and must continue to be addressed aggressively by HCFA and the PROs.

- The published number (4,724 cases) of premature discharges and inappropriate transfers reported to HCFA by MREs, FIs and PROs during the period 10/1/83 through 5/31/85 could not be verified. This is due to the phasing out of the MREs, inconsistent instructions given by HCFA, and inaccurate reporting by the PROs. Also, during the time frames mentioned above, 30% of the PROs were not reporting premature discharges or inappropriate transfers at all. Therefore, the overall extent of the problem is still not fully known.

- Of the 3,706 cases found, 90% were referred by the PROs; 10% were referred prior to PRO implementation. One hundred and fifty-seven (4%) of the 3,706 cases were inappropriately referred. Of the remaining 3,549 cases, 82% were premature discharges, 14% were inappropriate transfers, and 4% could not be categorized by type.

- Quality issues ranging from very minor to gross and flagrant were identified by the PROs in 60% of the 3,549 cases. PRO disposition ranged from intensified review of identified hospitals and physicians to no action being taken at all. In 43% of the cases with identified quality issues the only apparent action taken by the PRO was referral to HCFA.

- Medical records involving 133 patients were referred to OIG physician consultants for review. Nineteen were classified by OIG consultants as exhibiting gross and flagrant instances of substandard care. PROs took no corrective action, other than referral to HCFA, on 12 of these 19 cases. In the opinion of the OIG medical consultants, inappropriate actions were taken on 106 of the 133 cases. These cases have been or will be returned to the PROs for various recommended actions.

- PROs did have the authority to take action on the quality issues identified in this study. It appears that many PROs have not effectively used the authorities or the processes available to address instances of poor quality care associated with premature discharges and inappropriate transfers.

- During OIG site visits conducted in September and December, 1985, problems were noted with the PRO's accumulation of data pertaining to the quality of care rendered by physicians and hospitals. This data is necessary for the identification of abusive patterns and subsequent corrective action.

- It should be noted that since the initiation of this inspection increased activity by HCFA and the PROs in this area has occurred. HCFA has issued Transmittal 6 (relating to sanction procedures) and has initiated focused reviews in this area. PROs are increasing sanction activities against physicians/providers demonstrating abusive patterns of practice.

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I. Purpose and Methodology

At the request of the Inspector General, a national program inspection was conducted of identified instances of premature discharges and inappropriate transfers occurring under Medicare's Prospective Payment System (PPS).

The objectives of this inspection were to:

1) Determine the number of premature discharges and inappropriate transfers referred to the Health Care Financing Administration (HCFA) by medical review entities (MREs), fiscal intermediaries (FIs), and Peer Review Organizations (PROs) from 10/1/83 through 5/31/85;

2) Categorize the cases and document their disposition;

3) Review the appropriateness of corrective action on cases where the PRO, MRE or FI, through its review process, identified potentially gross and flagrant or substantive instances of substandard care; and

4) Examine the procedures and instructions pertaining to the identification and disposition of these cases.

This inspection was not meant to determine the overall effect of PPS on quality of care rendered to Medicare beneficiaries. This broader issue will be more fully addressed in other Inspector General and HCFA reports scheduled to be released later in fiscal years 1986 and 1987.

According to HCFA, 4,724 cases of premature discharges and inappropriate transfers were referred to the HCFA regional offices between 10/1/83 and 5/31/85 by various medical review entities, including 33 of the 47 PROs located in non-waiver PPS states. The actual referrals were kept in the HCFA regional offices, excluding the New York region where all states are exempt from PPS. Office of Inspector General (OIG) teams went to the nine remaining HCFA regions to gather identifying information on the referral cases. During September and December, 1985 onsite visits were also conducted at 19 of the 33 PROs to record what actions were taken by them on cases with identified quality of care issues. The remaining 14 PROs who had referred to HCFA minimal numbers of cases were contacted by the HCFA Project Officers to ascertain the disposition of those cases. In all instances, the data gathered was what was documented in the PRO's case file. If corrective action was taken on cases but not documented in the material available to the reviewer, it was not recorded.

Discussions focusing on premature discharges and inappropriate transfers and HCFA instructions regarding these cases were conducted with HCFA's Central Office, the nine regional offices, all 47 PROs, and 15 state hospital associations. National associations such as the American Medical Association (AMA), American Hospital Association (AHA), American Peer Review Association (AMPRA), and American Association of Retired Persons (AARP) were also contacted.

II. Overview

In March, 1983, Congress passed legislation requiring a new system for reimbursing Medicare inpatient hospital stays. Implementation of the Prospective Payment System began on October 1, 1983, and by October 1, 1984, all non-exempt hospitals servicing Medicare inpatients were being paid based on 468 diagnostic related groups (DRGs). DRGs categorize patient stays based on principal and secondary diagnoses and surgical procedures.

Consistent with the new era of competition and sound financial practices pervading the private sector of health care, Congress built into Medicare's Prospective Payment System economic incentives to curb escalating costs and prevent overutilization of inpatient stays. PPS encourages the use of outpatient facilities. It rewards hospitals that provide efficient care by allowing them to keep the dollar differences between their actual operating costs and Medicare's DRG payment.

While the intent of Congress was to reduce health care costs, it was also concerned that the quality of health care not suffer under this new system. To ensure the integrity of PPS and to maintain the high quality of care afforded patients under the cost reimbursement system, Congress established and provided funding for Peer Review Organizations. The 54 PROs under contract with HCFA are located in each state, territory, and the District of Columbia. (Forty-seven PROs operate in non-waiver PPS states.) They are responsible for determining:

1) whether the services provided or proposed are reasonable and medically necessary for the diagnosis and treatment of illness or injury ...;

2) whether services ... could ... be effectively furnished on an outpatient basis ...;

3) the medical necessity, reasonableness, and the appropriateness of hospital admissions and discharges;

4) ...appropriateness of inpatient hospital care for which additional payment is sought under outlier provisions;

5) whether a hospital has misrepresented admission or discharge information or has taken an action that results in unnecessary admission ... unnecessary multiple admissions ... or other inappropriate medical or other practices ...;

6) the validity of diagnostic and procedural information supplied by the provider;

7) the completeness, adequacy, and quality of hospital care provided; and

8) whether the quality of services meets professionally recognized standards of health care.

(Peer Review Organization Manual, IM 2001.1)

To assist the PROs in carrying out their responsibilities, Congress gave them authority to deny payment for inappropriate services, to take corrective actions as necessary and to sanction physicians and hospitals providing poor quality care, or attempting to circumvent the new system.

Between October, 1983, and October, 1984, MREs and FIs were responsible for handling quality of care issues as PPS was being implemented. By October, 1984, all non-exempt hospitals were being reimbursed by Medicare under PPS, and almost all of the 54 PROs were operational.

As the PROs became operational, they began encountering situations that involved premature discharges and inappropriate transfers. Either of these situations could indicate a hospital and/or a physician attempting to circumvent or "game" the system.

Premature Discharges/Inappropriate Transfers

A premature discharge is the release of a patient who is still in need of acute hospital care. If the patient returns to the hospital, the hospital receives a second DRG payment. If the patient does not return to the hospital, the hospital still benefits financially by having expended less of its resources than would have been expended had the patient stayed until acute level care was no longer required.

An inappropriate transfer is the transfer of a patient, for no discernable reason, from an acute hospital to another acute hospital or from an acute hospital to an exempt non-PPS unit (e.g. rehabilitation, psychiatric, and alcohol/drug treatment units). The Medicare program suffers financially when patients are inappropriately transferred back and forth because each facility involved receives reimbursements either through DRGs, per diem payment, or on a cost basis.

MREs, FIs and subsequently PROs were required to review all readmissions to a hospital within seven days, and all patient transfers. Instructions regarding the identification and processing of these cases were contained in HCFA's Transmittal 107 issued in November, 1983, and are now incorporated into the PRO manual. These initial instructions dealt only with cases that were determined to be medically unnecessary stays or medically unnecessary transfers. If the care rendered during the readmission or following the transfer was determined to be unnecessary, denial of the second stay could be made. If a pattern of unnecessary admissions or transfers was identified, development of a sanction recommendation was to be initiated if violations of Section 1156 of the Social Security Act were in evidence.

Falling outside of the scope of the initial instructions issued by HCFA were instances of premature discharges and inappropriate transfers where the resulting stay was medically necessary, or the reason for transfer was not apparent, although the care was necessary.

These cases were to be referred into the HCFA regional offices for analysis, pending a Departmental legal decision regarding how to implement the authorities under Section 1886(f)(2) of the Social Security Act, which authorizes PROs to deny stays and initiate sanction action in instances where PPS is being manipulated or circumvented. It was assumed by HCFA that the PROs would handle any quality issues associated with these cases in accordance with PRO authorities and procedures. These provide for educational contacts, intensified review and ultimately sanction of providers if violations of Section 1156 are identified.

In July, 1985, HCFA issued Transmittal 5, which instructed the PROs to deny payment in certain circumstances for readmissions resulting from premature discharges and for inappropriate transfers, and to initiate sanction development based on prescribed criteria.

III. Case Reconciliation

- Of the 4,724 premature discharge and inappropriate transfer referrals reported by the HCFA regional offices from 10/1/83 through 5/31/85, 2,688 (57%) of the cases could be located.
- Of the referral cases, 2,165 were reported by HCFA to be MRE/FI referrals and 2,559 were PRO referrals. 17% (370) of the MRE/FI referrals and 91% (2318) of the PRO referrals were located during this study.
- In addition, 282 cases referred after 5/31/85 were reviewed and 736 cases that were never referred were identified and categorized.
- In all a total of 3,706 cases were reviewed.

To put these numbers in perspective, it should be noted that from implementation of PPS through May, 1985, MREs/FIs and PROs reviewed, for a variety of reasons, approximately 2.1 million cases. The 4,724 referrals made to HCFA were contained in a universe of approximately 345,700 cases. Identified premature discharges and inappropriate transfer cases referred to HCFA by the PROs account for approximately 1.4% of this specific universe.

However, because of inconsistencies, inaccuracies and non-reporting, any broad conclusions drawn, based on these figures, would be unfair and inaccurate.

After PRO implementation the vehicle for referring premature discharges and inappropriate transfers was the "Monthly Medical Review Report" (HCFA-516). Summaries of case referrals were expected to be attached to the HCFA-516s.

It was anticipated that the referrals made prior to PRO implementation might be difficult to locate, and indeed only 370 of the 2,165 MRE/FI referrals could be found. It appears that most of the case information was destroyed or warehoused by the MREs/FIs when the PROs became operational.

In a few regions PRO referrals were also hard to find. Case summaries supporting the numbers on the HCFA-516s in some instances could not be located or the identifying information on the referrals was not complete enough to associate it with a HCFA-516. This made categorization of those cases impossible. On-site visits to the PROs became more difficult because the PROs were required to locate the referral cases without identifying information and then document action on quality issues. Because of this confusion, 282 cases referred into HCFA after 5/31/85 were categorized, as well as 736 cases that were found on-site at PROs that had never been referred. In all a total of 3,706 cases were reviewed in this inspection.

Explanations for the difficulty in finding the referral cases varied. HCFA, in issuing instructions regarding these referrals, did not stipulate a format or the type of information that should be contained in the referrals. The regional offices did not give uniform instructions to PROs regarding these referrals. Some regions indicated they wanted only the number counts, while others issued explicit instructions on what to send in, including cases involving quality issues or anything that was of a sensitive nature.

Due to the inconsistency of the instructions the PROs were confused regarding their reporting responsibilities. This is evidenced by the disparity in the number of cases reported by each PRO and in the 30% of PROs who referred no cases at all. There is also no direct relationship between the number of cases referred, Medicare hospital utilization within the state, or review activity by the PROs. In addition, of the cases that were located and identified, approximately 4% were inappropriate PRO referrals that did not involve premature discharges or transfers. The chart on page nine indicates total referrals reported on the HCFA-516s, and case summaries actually located.

The lack of referrals and inconsistent referral rates can be attributed to systems problems experienced by FIs and PROs in identifying these cases; unclear, misunderstood, or disregarded instructions; duplicate counts; amended HCFA-516 reports; and confidentiality concerns by the PROs.

Of the 3,706 cases reviewed, 90% were referred in by PROs, 6% by MREs, and 4% by FIs. Eliminating the inappropriate referrals reduces the case count to 3,549. It is these 3,549 cases which are discussed in the body of this report.

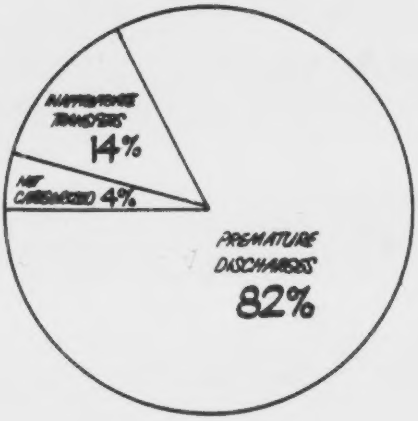
CASE RECONCILIATION

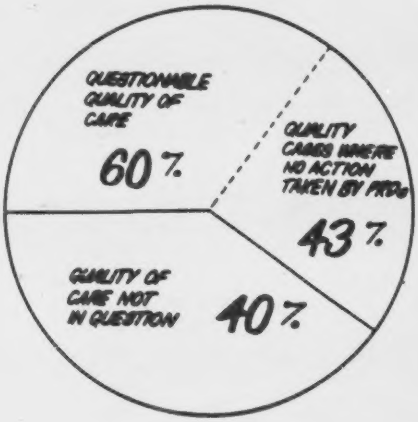
CASES REPORTED BY HCFA 10/1/83 - 5/31/85		CASES FOUND	PERCENT FOUND
MREs/FIs	2165	370	17%
PROs	2559	2318	91%
TOTAL	4724	2688	57%
CASES REPORTED AFTER 5/31/85		282	
CASES NOT REPORTED		736	
TOTAL CASES FOUND		3706	
LESS ERRONEOUS REFERRALS		157	
TOTAL		3549	

IV. Categorizing Cases and Documenting Dispositions

- Of the 3,549 cases reviewed, 82% were identified as being premature discharges, 14% were inappropriate transfers and 4% could not be categorized by type because of insufficient information.
- Of these cases, 60% were identified as quality issues by the PROs.
- In 43% of the quality issues identified, the only apparent action taken was referral to the HCFA regional offices.
- Of 2,146 cases with apparent quality issues, 133 patients' records were referred to OIG physician consultants to review the appropriateness of PRO action.
- PRO action was found to be inappropriate in 106 of the 133 cases reviewed by the OIG.

Quality issues were coded when a PRO physician advisor had identified them in case documentation. It should be noted that the magnitude of the quality issues identified by the PROs varied from very minor to potentially very serious. However, the review teams did not attempt to categorize the severity of the issues.


CATEGORIZE CASES


QUALITY ISSUES

Premature Discharges

The premature discharges discussed in this review were identified as such by the PROs in their reviews of a subsequent readmission. The PROs referred these cases to the regional offices because the patients:

- were not appropriately treated;
- were appropriately treated but released too early in the course of treatment;
- were discharged in a medically-unstable condition; or
- were discharged to be readmitted for further treatment when all treatment could have been rendered in the first admission.

If a patient is released prematurely it is almost always at the physician's direction. However, there may be extenuating circumstances. In 70% of the 2907 premature discharges reviewed, it appeared the physician was solely responsible for the discharge. In the remaining 30% of the cases the discharge was not directly attributable to the physician. For example:

1) In 23% of the premature discharges, the patient was admitted for a diagnostic workup, released, and readmitted for surgery. These situations included cardiac catheterizations with readmissions for bypass surgery and biopsies with readmissions for major surgery. The first situation is standard in many hospitals: the bypass surgery is not scheduled until the results of the catheterization are known. The second is frequently due to the patient's wish to settle his/her affairs before major surgery.

2) In three percent of the premature discharges, the patient was discharged at his or her own request or the family's request.

3) In one percent of the cases, the patient left the hospital against medical advice.

4) In three percent of the cases, miscellaneous reasons accounted for the discharge.

In a very few instances, as annotated in the record reviewed, the physician discharged the patient because the physician had presumably been informed by the hospital administration that the resources expended on the patient were going to exceed the DRG payment, causing financial loss to the hospital.

The PROs also identified cases in which the patient was discharged as no longer needing acute care but was unable to manage at home, necessitating a readmission. A possible explanation for these situations is poor discharge planning. The patient should have been placed in a skilled nursing facility or referred for home health services . However, based on the sometimes limited information available it was difficult to determine if readmission was due to poor discharge planning or a premature discharge.

Inappropriate Transfers

Generally, a transfer is necessitated by the inability of a hospital to provide a necessary service or a procedure, or because a patient is in need of a specialized therapy, i.e., rehabilitative or psychiatric care. The initiation of a transfer is based on an order by the attending physician who determines the level and type of care the patient needs.

Of the 519 transfer cases reviewed, the majority of patients, 79%, were transferred from one acute care hospital to another; 4% to a rehabilitation unit; 2% to a psychiatric unit; and in 8% of the cases the destination was not known.

In almost 7% of the cases reviewed, patients were "transferred" inappropriately to skilled nursing facilities or swing beds. By HCFA definition, a patient is admitted to these facilities, not transferred. However, for purposes of this review, these cases were considered transfer cases.

In 58% of the transfer cases reviewed, the reason for transfer was not apparent. The remaining transfer cases represented situations where an inappropriate transfer occurred that could not be attributed to the physician or hospital. They are as follows:

1) In 29% of the transfer cases reviewed, requests for transfer were made by the family. In some of these cases, the patient had been admitted to a community hospital that did not have the expertise to complete tests and perform necessary procedures. Therefore, the patient was appropriately transferred to a larger tertiary hospital which, in some rural areas, could be located a great distance from the patient's home, family and friends. Once necessary tests and procedures were performed, the family or patient requested transfer back to the community hospital for convalescence, which could have taken place in the tertiary hospital.

2) In 12% of the cases miscellaneous or unclear reasons accounted for the transfer.

3) In 1% of the cases, the patient refused treatment at the receiving hospital and was sent back to the transferring hospital.

4) In a very small percentage of cases documentation in the record indicated that a patient was transferred from an acute care setting to a specialty unit because if he/she stayed in the acute hospital longer he/she would exceed the "average length of stay", hospital resources expended might exceed DRG payment, and the hospital might suffer a financial loss.

PRO Disposition of Cases With Quality Issues

PRO follow-up activities were generally categorized into educational contacts, intensified review, and referral to HCFA only. In 43% of the 2,146 cases with identified quality issues, no action other than referral to HCFA was taken. The remaining actions taken by the PROs when quality issues were identified are categorized as follows:

1) Educational Contacts

In 35% of the cases the PROs made educational contacts. The educational contacts ranged from sending the attending physician and hospital utilization review (UR) committee a copy of the referral to HCFA; to a telephone call to the attending physician by the PRO physician reviewer; to a carefully documented letter to the physician with a copy to the hospital UR committee detailing the PRO's analysis of the case. Many more of the former two practices were noted in this review. In very few instances was the phone call well documented, giving any details of the conversation, date or time. In some cases contact was made with the hospital UR committee instead of the physician, or in addition to the physician.

2) Further Review Determined No Problem Evident

In 10% of the cases it was determined that based on either additional information or review by a second PRO physician, there was no quality issue involved.

3) Intensified Review

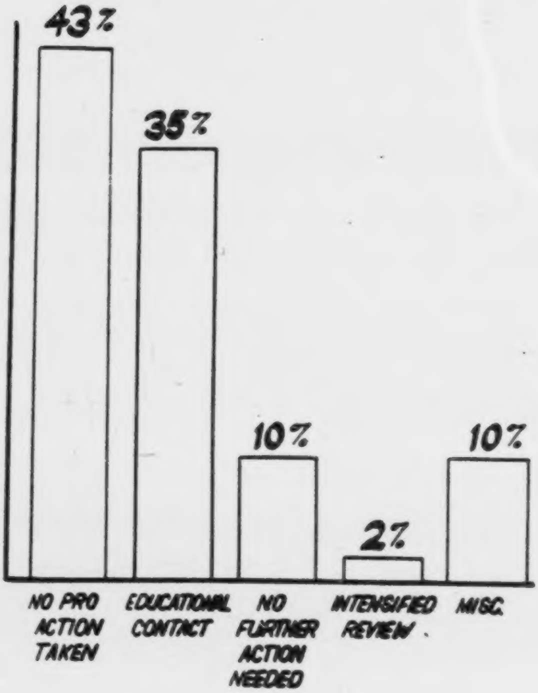
In 2% of the cases reviewed the PROs instituted intensified review of the hospital or physician.

4) Sanction Development

In no instance was a sanction development initiated by the PROs.

In 10% of the cases, actions such as referral to the PRO quality assurance committee; PRO development underway; PRO unable to locate record; etc., were recorded in a miscellaneous category.

PRO DISPOSITION OF CASES WITH QUALITY ISSUES



Quality Issues

Sixty percent of all cases reviewed involved quality concerns. The quality issues ranged from very minor to gross instances of substandard care. Of the 2,146 cases identified as having quality concerns, 2,050 were premature discharges, 42 were inappropriate transfers, and 54 were diagnostic workups with a readmission for surgery. It should be noted that not all of the 2,907 cases identified as premature discharges were classified as being quality issues. Generally the diagnostic workups with readmissions for surgery, while classified as premature discharges by HCFA definition, did not involve substandard care. Prior to PPS this was acceptable hospital practice. In addition, quality of care was generally not a concern in transfer cases. However, some patients were transferred in unstable condition or for inappropriate care, and some of the patients sent home to await surgery deteriorated in the interim.

Substantive issues accounted for the vast majority of the cases reviewed. The types of situations which were identified most often included:

1) conditions not adequately treated, such as indications of urinary retention, infection, etc., being acknowledged but not addressed prior to discharge;

2) secondary conditions uncovered by laboratory analyses not being acknowledged or addressed until readmission;

3) failure to perform routine laboratory tests, or failure to document vital signs, leading to missed diagnoses.

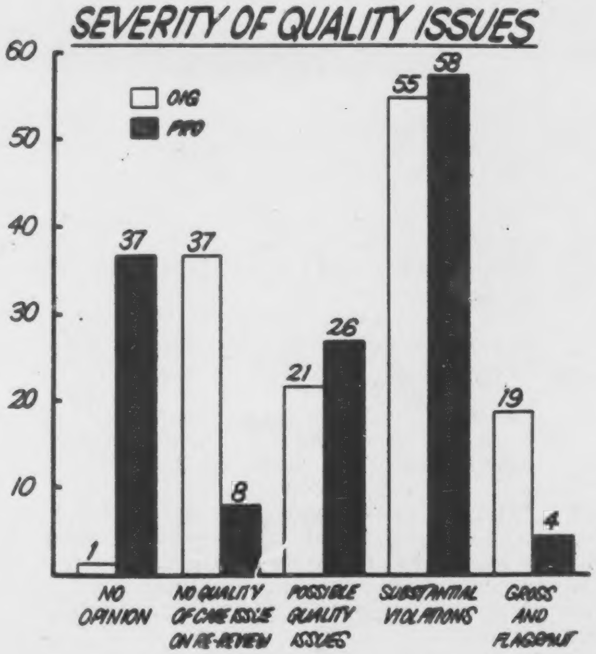
All of these cases had been identified as quality concerns by the PRO physician reviewers. When the OIG reviewers saw cases in which the situations above appeared to have placed the patient in great jeopardy, copies of the medical record were requested for further review by OIG physician consultants.

The OIG physicians reviewed medical records for 133 patients and, if attached, PRO worksheets and opinions by nurse reviewers or PRO physician advisors. After analysis,

sis, the cases were then grouped into the following categories: gross instances of poor quality of care; substantial instances; possible instances; no instance of violation; and no opinion of the case reviewed. PRO physicians' comments on these cases were also categorized. The result is displayed on the following chart:

OIG MEDICAL REVIEW

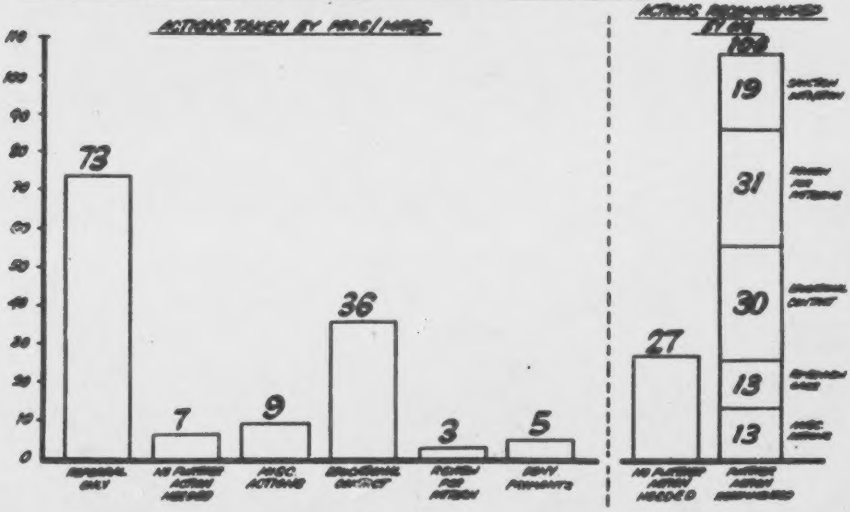
OF 133 CASES


SEVERITY OF QUALITY ISSUES

In 55% of the 133 cases, PROs referred the cases to HCFA and no further action was taken. In 27% of the cases an educational contact was made. In the remaining cases a number of actions, such as referral to the PRO quality assurance committees, were made. In no instance was a sanction development initiated.

OIG physicians recommend that sanction development be taken in 14% of the cases; additional review of more recent cases be done on specific hospitals and physicians identified in 23% of the cases; educational contacts be made in 22% of the cases; no action in 21% of the cases; and rereview of the case by the PRO in 10% of the cases. In the remaining 10%, various other actions are recommended.

OIG MEDICAL REVIEW OF 133 CASES



In summary, medical records for 133 patients were reviewed by OIG physician consultants. It was their opinion that 19 of these cases represented instances of gross and flagrant violations. Fifty-five represented substantial violations of acceptable medical practice, 21 represented possible violation, 37 cases had no quality issues on review, and in one case OIG physicians had no opinion. Forty cases with identified quality issues where inappropriate action were taken by the PROs have been returned to them for sanction development. The remaining 66 cases will be returned through HCFA to the PROs for various recommended actions.

V. Mechanisms to Address Cases of Premature Discharge or Inappropriate Transfer

- The profiling of physicians and providers necessary for the identification of abusive patterns is for the most part being done manually by the PROs.
- HCFA instructions contained in Transmittal 5 were well received by some PROs, but many expressed a need for further clarification.
- Sanction recommendations regarding these cases are not being made by the PROs in accordance with available PRO authorities.

Based on the findings of this inspection it appears that many PROs have not effectively used the authority or the process available to them to address instances of premature discharge and inappropriate transfer. This is due in part to their inability to identify patterns of abuse, the lack of clarity and adequacy of HCFA instructions pertaining to these cases, and an apparent reluctance to implement corrective actions and carry out educational responsibilities when instances have been identified.

The prevention of premature discharges and inappropriate transfers is part of the PROs' ultimate goal of protecting the integrity of the system while safeguarding the quality of care provided through this system.

The process enabling the PROs to address premature discharges and inappropriate transfers involves:

1) identification, tracking and profiling of providers and physicians;

2) review and assessment of the appropriateness and quality of care;

3) use of corrective measures and communicative approaches designed to educate and instruct providers and physicians, as well as denial of payment and sanction actions.

Identification and Profiling

HCFA requires that all PROs have profiling capabilities. Yet, very little profiling was being done of the providers and physicians identified in the premature discharges and inappropriate transfers reviewed in this inspection. Profiling that was occurring was for the most part being done manually.

A total of 1,158 hospitals could be identified in this study, 392 of which had three or more cases identified as being premature discharges or inappropriate transfers. One hundred eighty-five had five or more cases identified, 85 had eight or more instances and 53 hospitals had 10 or more instances identified during the time frames of this review. Those hospital providers identified as having more than 10 instances of premature discharges and inappropriate transfer will be brought to the PRO's attention by HCFA for additional development to determine if patterns of substandard care exist.

In order for the current system to work, it is essential that individual instances of premature discharges and inappropriate transfers be identified and dialogue initiated with the physicians and hospitals involved to prevent further occurrences.

Under current policy the denial of the second stay should serve to deter the physician and/or hospital from manipulating or circumventing the system, but it will not facilitate the identification of patterns of poor quality care unless profiling of physicians and hospitals also occurs.

Due to the heavy volume of cases reviewed by the PROs it is essential that profiling of quality issues be automated. Not only would this provide for accurate tracking and analysis, it would also facilitate HCFA monitoring processes and PRO reporting responsibilities.

As noted on the chart on page 25 the PROs initially had difficulties in identifying potential premature discharges and inappropriate transfers due to data exchange problems with the respective FIs. Case control problems as mentioned earlier were also identified during the conduct of this review.

HCFA Instructions

The issuance of Transmittal 5 addressed in part situations where premature discharges and inappropriate transfers were occurring. HCFA provided guidance to the PROs on how to handle certain situations that were in violation of Section 1886(f)(2) of the Social Security Act. Generally, the PROs were glad to receive the instructions contained in Transmittal 5. However, when asked if the instructions were adequate and could feasibly be incorporated into the existing processes, they were less unanimous in their responses.

Half of the PROs felt that the instructions were not realistic and need further clarification. The focus of many of the PROs' concerns revolved around the denial of the second hospital stay rather than the first (which resulted in the premature discharge). Also, they appeared to be somewhat unclear regarding the hospital appeal rights should payment be denied and the effect of waiver of liability in these situations, although these issues are addressed in Transmittal 5.

Some PROs felt the criteria stipulated by HCFA which would indicate a pattern of circumventing PPS and necessitate initiation of a sanction development was not consistent with the current sanction procedures. PROs also felt that the trigger of a sanction development based on three inappropriate transfers or premature discharges in a quarter would unfairly penalize larger hospitals. Related concerns expressed by the PROs are the potential effect on their staffing and budgets that would result from increased sanction activity.

Not covered in these instructions are situations where a patient is readmitted to a different hospital. In addition, the instructions do not address premature discharges that do not result in another hospital stay, nor do they apply if the patient or family requests the discharge. Also not addressed are situations where proper discharge planning would have prevented the necessity for the second admission.

Areas that were not clear to the PROs were:

1. Effective date of the instruction;

2. Whether the criteria triggering initiation of a sanction applies to an individual physician or the hospital.

3. Whether to:

    1. Recommend sanction based on

        A. quality which does not meet professionally recognized standards under Section 1156(a)(2) of the Social Security Act; or

        B. circumvention of the system, Section 1886(f)(2); or

    2. Refer for termination of the provider agreement under 1866(B)(2).

4. Whether the requirement to refer premature discharges and inappropriate transfers into HCFA via the HCFA-516 is still in effect.

Use of Educational, Preventive, and Corrective Measures

Prior to issuance of Transmittal 5 in July, 1985, the PROs were not authorized to deny payment for premature discharges and inappropriate transfer, pending a legal determination regarding the propriety of this action. Although PROs now have instructions regarding this authority, it is too early to determine if the financial loss to hospitals resulting from the identification of such practices will serve as a deterrent in the future. However, PROs have always had the responsibility to document patterns of substandard care and initiated corrective actions.

With the issuance of Transmittal 5 the PROs have received instructions and been given criteria that if met should trigger a sanction development based on circumvention of PPS.

A number of PROs expressed the opinion that if they were adequately performing their educational and preventive role, punitive actions would not have to be taken as frequently. Indeed the current process encourages an early warning to a physician or hospital to prevent the necessity for drastic action later on.

However, as mentioned earlier, the PROs are not consistent in how often or to what extent educational contacts are made with the hospital physician community when poor quality care has been identified.

Documentation of educational contacts, whether phone calls or letters, could be found in fewer than half of the cases identified by the PROs as having indications of poor quality. In some instances, the OIG physician reviewer determined that, on available evidence, the care was in gross and flagrant violation, yet only a referral to the HCFA Regional Office had been made.

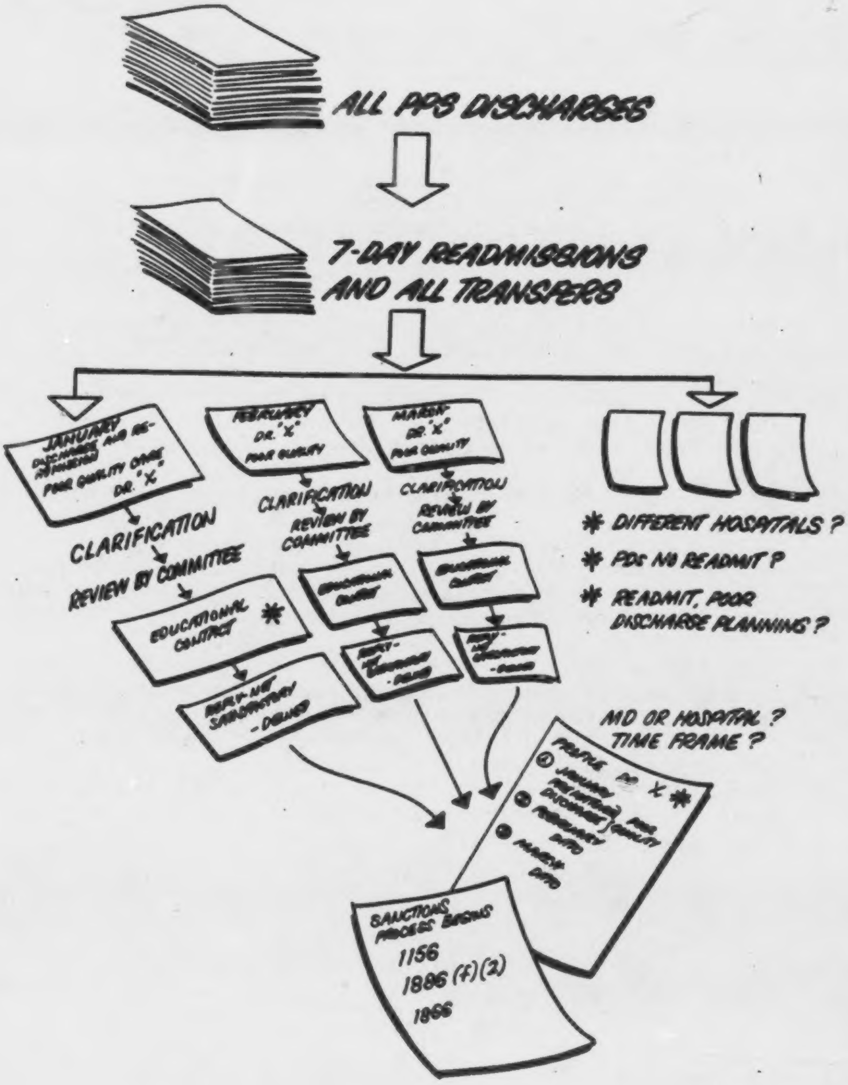
In instances where a copy of the letter sent to the physician was available, it frequently did not document the nature of the violation or the PRO's specific concerns.

It is essential to the PRO monitoring process to document that educational contacts of a specific nature have been made with physicians and hospitals when quality issues have been identified. It is also essential to the development of a sanction case should the necessity arise.

There was no uniformity or consistency in the cases reviewed regarding: when an educational contact was made; the content of the notification; with whom the contact was made; or documentation of the contact.

The following is a diagram of the process to identify, track, and prevent the occurrence of premature discharges and inappropriate transfers. Asterisks are used to identify weaknesses in this process that have been discussed throughout this report. Correction of these weaknesses and aggressive use of this process by the PROs should prevent occurrences of premature discharges and inappropriate transfers in the future.

PROCESS


ALL PPS DISCHARGES
7-DAY READMISSIONS
AND ALL TRANSFERS
JANUARY
DISCHARGE AND RE-ADMISSION
POOR QUALITY CARE
DR. "X"
CLARIFICATION
REVIEW BY COMMITTEE
EDUCATIONAL CONTACT *
REPLY-NOT SATISFACTORY
- DENIED
FEBRUARY
DR. "X"
POOR QUALITY
CLARIFICATION
REVIEW BY COMMITTEE
EDUCATIONAL CONTACT
MARCH
DR. "X"
POOR QUALITY
CLARIFICATION
REVIEW BY COMMITTEE
EDUCATIONAL CONTACT
* DIFFERENT HOSPITALS ?
* PDs NO READMIT ?
* READMIT, POOR DISCHARGE PLANNING ?
MD OR HOSPITAL ?
TIME FRAME ?
PROFILE DR. X *
① JANUARY READMISSION DISCHARGE
POOR QUALITY
② FEBRUARY DITTO
③ MARCH DITTO
SANCTIONS PROCESS BEGINS
1156
1886 (f)(2)
1866

VI. Recommendations

1. HCFA should:

    - Continue its reporting requirements regarding premature discharges and inappropriate transfers. Instructions regarding PRO referrals should be clarified and a uniform format for referrals developed. Uniform PRO referral of these cases will help to identify the magnitude of this problem and assess the effectiveness of the policies contained in Transmittal 5.

    - Issue clarification of TRansmittal 5 immediately, in response to specific PRO concerns.

    - Expand the PROMPTS review to include monitoring of a sample of referral cases, from identification through PRO corrective actions, to ensure the process for handling these cases is being correctly implemented.

    - Reassess, through PROMPTS, PRO operational procedures and systems for identifying, profiling and tracking instances of poor quality care attributable to physicians and hospital providers. PROs should have the automated capability of identifying patterns of substandard care. Deficiencies or system problems should be noted and corrective actions taken.

    - Develop guidelines and model letters regarding the issuance, content, and documentation of educational contacts made prior to sanction develpment.

    - Initiate studies to determine the extent to which poor discharge planning is resulting in hospital readmissions.

2. The OIG concurs with HCFA that PRO scopes of work should be revised to place more emphasis on PRO responsibility in monitoring quality of care.

3. The Department should continue to encourage passage of Senate Bill 1623, incorporated in the Senate Reconciliation package, which would authorize PROs to

deny payment for identified instances of substandard care, of a substantive nature, rendered to Medicare beneficiaries.

AARP

February 26, 1986

Senator Christopher J. Dodd
Special Committee on Aging
628 Senate Hart Office Building
Washington, DC 20510

Dear Senator Dodd:

I am responding to your questions to me concerning quality of care problems under Medicare's prospective pricing system (PPS).

Q. Is PPS basically compatible with quality of care for Medicare beneficiaries?

The answer is that it can be compatible with high quality care IF we are committed to making quality a priority of the system. Unfortunately, the quality of patient care has not been a high priority of HCFA and thus has not been a priority for the peer review organizations charged with monitoring and safeguarding quality.

The basic problem is that HCFA has refused to monitor those places in the system where quality is likely to be compromised. HCFA simply does not have the information to claim, as it does, that quality is not a problem under PPS.

And although the most recent scope of work requirements for the second round of PRO contracts is an improvement over the first, a great deal remains to be done so that patients and policy makers, bureaucrats and doctors can discuss the quality of medical care and understand what each other is talking about.

I believe the recommendations beginning on page 11 of my November 12, 1985, testimony to the Senate Special Committee on Aging (attached hereto) sets forth the actions that must be taken to assure quality medical care, not just for Medicare patients, but for younger patients, too.

Q. How useful can an advocacy program be in assisting Medicare patients prematurely discharged from hospitals?

Given the proper tools, an advocacy program can be very helpful in assisting Medicare patients prematurely discharged from hospitals. The tools necessary for such a program, however, are grossly inadequate under current law and regulations. For example, the current appeals process for continued stay denials is deficient. The timing and content of the hospital "notice of noncoverage" raises many questions. The unavailability of appeal rights until the patient

American Association of Retired Persons 1909 K Street, N.W., Washington, D.C. 20049 (202) 872-4700

Vita R. Ostrander *President* Cyril F. Brickfield *Executive Director*

places himself at financial risk is causing the patient to leave rather than challenge a denial of benefits. If the patient is not willing or is unable to risk his own funds, he will be discharged and there will be no expedited appeal. A basic commitment to quality care requires an appeals process capable of testing decisions to deny coverage on a case by case basis before benefits are terminated.

In addition, an advocacy program must also include patient education about the process and beneficiary options. HCFA has been wholly remiss in this aspect of its responsibilities to Medicare beneficiaries.

Q. How effective is the long-term care (LTC) ombudsman in each state?

Because the ombudsman program is governed to such a large extent by each state's laws and regulations, it is difficult to make a general statement about the ombudsmen's effectiveness. In those states which support the ombudsman's access to information and facilities and which provide adequate funds to perform their responsibilities as well as coordinate their findings and reports with appropriate agencies, ombudsmen have been very effective. AARP believes stronger federal support of an expanded ombudsman's role can contribute to the quality of care provided all hospital and nursing home patients.

I hope these responses will assist you and the Committee in developing legislation that will assure the quality of medical care Americans of all ages want for themselves and their families.

Sincerely,

Vita R. Ostrander

Vita Ostrander
President

INDEX III

DOCUMENTS AND CORRESPONDENCE PERTAINING TO HCFA MANAGEMENT OF THE PRO PROGRAM PROVIDED BY THE ALABAMA QUALITY ASSURANCE FOUNDATION, INC.

ALABAMA QUALITY ASSURANCE FOUNDATION, INC.
FACT SHEET

PHYSICIAN ATTESTATION

I. PROBLEM

The PRO is to monitor the hospitals' compliance with "attestation" requirements. Monitoring has been difficult due to conflicting and changing Central and Regional Office instructions regarding acceptable "attestation" formats and legal signatures to be used in physician "attestation" requirements.

II. BACKGROUND

A. PROs are responsible to assure that Medicare payments under PPS are correct by identifying whether the diagnostic and procedural information reported by hospitals for DRG assignment is correct and matches the information contained in medical records. This includes review and ascertains that the attending physician has "attested" to the diagnoses and procedures used for Medicare billing purposes. The physician attestation is a condition of payment under PPS and must be present in the medical record for every claim.

B. Unacceptable "attestation" formats and physician signatures are cited as PRO deficiencies during Regional Medical Team Monitoring visits.

C. As a result of three (3) Regional Monitoring Visits and HCFA policy changes, Alabama Quality Assurance Foundation, Inc. has generated six (6) General Memorandums to Alabama hospitals regarding the clarification of "attestation" requirements (format and/or legal signature).

III. DISCUSSION

Listed below is a brief summary of policy changes and the Foundation's response to the "attestation" issue:

A. **02/22/84:** Letter to Alabama hospitals outlining requirements per PSRO Transmittal #107 (physician attestation and penalty notice combined) (Enclosure I).

B. **09/27/84:** General Memorandum #84-08 containing Federal Register final rules for PPS review effective October 1, 1984. This **amended** attestation requirement - separated physician attestation statement and penalty notice. (Enclosure II) The Foundation had received no implementing instructions from HCFA.

C. **10/28/84:** General Memorandum S84-10 emphasizes the need for compliance with physician attestation requirements per Federal Register final rules (i.e. physician's actual signature and charges are to be initialled).

D. 02/27/85: General Memorandum #85-03 addresses results of Regional Medical Review Teams initial monitoring visit. This included insistence that physician's "attestation" statement be correct in every aspect (i.e. full signature - no initials, stamps or partial signatures; any changes must be initialled by physicians).

E. 03/19/85: Foundation received the PRO Interim Manual Transmittal which describes PRO Medical Review responsibilities effective March 25, 1985.

"Attestation" requirements now include the following:

1. Physician must now date his/her signature;
2. Diagnostic or procedural changes must be countersigned and dated - not just initialled;
3. Hospitals must maintain a "Notice to Physicians" separate from attestation statements;
4. Hospitals must assure that the "notice" acknowledgments are updated October 1 of each year.

F. 05/28/85: Second Regional Medical Review Team monitoring visit report sent to the Foundation. The team cited individual and isolated cases of problems with physicians' full signature on "attestation" statements. IM 85-2 states that isolated problems of signatures do not warrant action, only patterns; however, the Review Team cited problem signatures as deficiencies.

G. 06/05/85: General Memorandum #85-09 was forwarded to educate Alabama hospitals on IM 85-2 requirements effective with hospitals' July 1 discharges. (Enclosure III) A copy was forwarded to our project officer for review.

H. 06/14/85: In response to Regional Office concerns, General Memorandum #85-09A amended the effective date of General Memorandum #85-09 from July 1, 1985 discharges to April 1, 1985 discharges. It also addressed what is considered a physician's legal signature.(Enclosure IV)

I. 08/09/85: General Memorandum #85-18 addressed a July 31, 1985 Regional Medical Review letter that granted relief from the April 1, 1985 implementation date of hospitals maintaining a "Notice To Physicians" on file separate from the "attestation" statement. The new implementation date of July 1, 1985 was originally established by Foundation General Memorandum #85-09.

It also clarified that an acceptable legal signature could include one or two initials plus the physician's last name written out if that was his "legal" signature. (Enclosure V)

J. 08/13/85: HCFA Baltimore Conference on DRG Validation and coding for PROs revealed two (2) "unofficial" HCFA issuances.

1. "Notice to Physician" acknowledgement date is no longer mandatory to sign on 10/01/85 (as stated in Interim Manual (IM 85-2)---date to be set by the hospital. To date no written notification of this change. Also, attendants at the conference were told by Central Office AQAF participants that by next June the "Notice" on penalty statements will probably be included on each chart.

K. The Foundation has strived to cooperate with the Regional Office in monitoring the hospitals compliance with the "attestation" statement. Multiple instructions on what is the acceptable format have resulted in making this PRO's responsibility laborious, intensive and frustrating. Hospitals have also been generally frustrated.

ENCLOSURE I.

ALABAMA MEDICAL REVIEW
236 Goodwin Crest Drive, Twin Towers East
BIRMINGHAM, ALABAMA 35209

STATE
PROFESSIONAL STANDARDS
REVIEW ORGANIZATION

TELEPHONE
205/942-5440

February 22, 1984

Gentlemen:

Enclosed are excerpts from PSRO Transmittal instructions concerning review under the prospective reimbursement system (PPS review) received February 21, 1984 by AMR. While AMR opposes some of the elements in the transmittal, and for a time was lead to believe that some of the objectionable elements would be removed, the requirements are now a "must" for PPS review implementation. The most objectionable and potentially the most financially damaging to providers element in the transmittal is the requirement (see Page 17 enclosed) for the attending physician to certify a specific statement on the medical record as a condition for payment of the hospital bill. As you can see, the PSRO is required to report failure to have the signed statement on the medical record during DRG validation review to the Fiscal Intermediary.

Request your cooperation and assistance in making sure a procedure is developed in each hospital to insure that medical records subject to PPS review have the required signed physician statement.

AMR regrets this imposition on both hospitals and physicians, but at the present time, no flexibility is provided to the PSRO in this matter.

Sincerely,

ALABAMA MEDICAL REVIEW, INC.

John W. Miller
Executive Director

Robert G. Sherrill, Jr., M.D.
Medical Director

cc: Alabama Hospital Association
Medical Association for the State of Alabama

Enclosures
/lh

ENCLOSURE I.

Enclosure 1

Memorandu

Date February 17, 1984 Clarence J. Boone

From Clarence J. Boone, Associate Regional Administrator
Division of Health Standards & Quality, Region IV

Subject Revision of PSRO Medical Review Instructions

Received Feb 21, 1984

To All Region IV PSROs

Attached you will find the second revision of the PSRO medical review instructions as issued by HSQB. You were asked to hold on implementation of the medical review instructions sent previously because of some policy considerations regarding timing of review. HSQB has decided, after reanalysis of the policy on timing of review, not to make any revisions. Consequently, the review timeframes outlined in the attached transmittal are to be considered final policy and must be implemented by all PSROs.

A comparison of these instructions with those issued recently indicate only very minor differences. Should you have any questions, please contact your project officer.

Enclosure I

1. The hospital must request cost outlier payment(s). The intermediary will not pay the cost outlier portion of the claim without PSRO review.

2. Subject all cost outliers to prepayment medical review. The review, using appropriate medical records plus the itemized bill, is to determine if the admission was medically necessary and appropriate and if all of the services rendered were medically necessary and appropriate.

3. The review will also be to determine that the diagnostic and procedural information is correct and that the services billed were:

   a. Not duplicatively billed,
   b. Actually rendered, and
   c. Ordered by the physician.

If some of the services are found to be not payable by Medicare, their cost will be excluded from the amount claimed by the hospital but only up to the amount which exceeds the outlier threshold. If an outlier cost is denied for medical reasons, make a recommendation regarding the application of the waiver of liability provision (Section 1879 of the Act) to the intermediary.

C. If a pattern of unnecessary outlier days or services within a particular hospital is identified, develop a sanction recommendation.

IV. DRG Validation

A. Conduct DRG validation at the hospital to ascertain that the diagnostic and procedural information that led to the DRG assignment is sustantiated by the medical records and that the admission was medically necessary and appropriate. (This includes making a determination that diagnostic studies and the course of treatment "match" the principal diagnosis, secondary diagnosis, and applicable procedures confirmed or attested to by the attending physician and that procedures related to the principal diagnosis are shown. The secondary diagnoses must be shown on the claim in the order attested to by the attending physician.)

1. If a hospital had greater than 360 Medicare discharges for the hospital's last year, review at hospital site at least once every quarter.

2. If the hospital had 360 or fewer Medicare discharges for the hospital's last year, the DRG validation must be performed onsite at the hospital at least once yearly. The other three quarterly reviews may be performed at the PSRO.

ENCLOSURE 1

3. Using Medicare discharges from that hospital in the last three months, select a full random sample. See attachment for sampling and universe review instructions. (If the PSRO is performing DRG validation every month, the sample would be drawn from discharges that occurred over the last month.) When a significant pattern of errors is noted, increase the review to 20% of that hospital's cases or continue review as outlined on the attached sample size chart, whichever is greater. A significant pattern exists when the number of cases with errors that result in a change in the DRG assignment from a hospital to total sample for the hospital is 2.5% or three cases, whichever is greater. As an alternative to 20% review, identify all subsets that have a 2.5% or three case error level (whichever is greater). The review of 100% of all such subsets can then be substituted for 20% review, except that under no circumstance may the total number of cases selected for DRG validation be less than the attached sample size chart. If the subsets are less than the sample specified, a random sample must be added so that the total number reviewed equals at least the level of effort specified in the sample size chart.

4. Also review all cases grouping to DRG 468.

5. In addition, review to ascertain that the attending physician has attested to the diagnoses and procedures used for Medicare billing purposes. Check to see that the physician's signature is preceded by the following statement:

> "I certify that the identification of the principal and secondary diagnoses and procedures performed is accurate and complete to the best of my knowledge. (NOTICE: Intentional misrepresentation, concealment, or falsification of this information may, in the case of a Medicare beneficiary, be punishable by imprisonment, fine, or civil penalty.)"

The requirement that this statement precede the physician's signature is effective February 2, 1984.

In rare instances, it may become necessary for changes to be made to the diagnoses and procedures attested to by the physician (e.g., the results of an autopsy may confirm a diagnosis that was not confirmed before the beneficiary's death). In these cases, the codes may be changed, but the physician must countersign these changes.

If it is determined that the physician did not attest to the diagnoses and procedures before the Medicare claim was submitted or that the attestation was not in the required format (e.g., the penalty statement was not present), notify the fiscal intermediary, as this requirement is a condition for payment. (Refer to 42 CFR 405.472.)

ENCLOSURE II

QUALITY
AQAF
UTILIZATION APPROPRIATENESS
STATE PEER REVIEW ORGANIZATION

ALABAMA QUALITY ASSURANCE FOUNDATION
SUITE 300, TWIN TOWERS EAST
236 GOODWIN CREST DRIVE
BIRMINGHAM, ALABAMA 35209
TELEPHONE (205) 942-0785

GENERAL MEMORANDUM #84-08

MEMO: HOSPITAL ADMINISTRATORS AND CHIEFS OF STAFF

COPY: BRHC, ALAHA, MARY GREGORY, PO/DHHS

FROM: JOHN W. MILLER, MPA, CHIEF EXECUTIVE OFFICER

DATE: SEPTEMBER 27, 1984

SUBJ: PHYSICIAN ATTESTATION STATEMENT

I. This memorandum modifies the requirement in the AMR letter of February 22, 1984 (Attachment I) for DRG Validation Review of the Physician Certification requirements.

II. Attachment II is an excerpt from the Federal Register containing the final rules effective October 1, 1984, for PPS Review. Your attention is invited to Section 405.472.

III. The Foundation has received no implementing instructions from HCPA changing or modifying the final rules in the Federal Register.

IV. Because of the short-time available to implement the new physician statement rules, the old (Attachment I) statement will be acceptable for discharges through October 31, 1984. Review conducted on discharges after October 31, 1984 will be to verify that:

1. The statement required by Section 405.472 (d)(2)(i) is signed by the Attending Physician.

   This statement may be stamped or reproduced in some written form on the medical record but the physician signature must be an actual signature, not a reproduced facsimile.

Enclosure II

2. The hospital has on file the "Notice to Physician" in Section 405.472 (d)(2)(i) with a signed (within the year prior to the submission of the claim for the discharge under review) acknowledgement that the Attending Physician has received the notice. It is suggested that the hospital reproduce the "Notice to Physicians" followed by a Statement of Acknowledgement signed by each Attending Physician attesting to the medical information in the medical record. The hospital should keep the notices on file in an area readily accessable to the medical record department.

V. It must be emphasized that the Foundation as the PRO for Alabama has no discretion or choice in the DRG Validation Review concerning the presence of the required "Attestation Statement" and "Notice to Physicians". While the old statement will be acceptable through October 31, 1984 discharges, discharges after October 31, 1984 must meet requirements 1 and 2 above.

VI. Your continued cooperation with the Foundation efforts to provide a fair, equitable review system that does not place the hospitals of Alabama at unnecessary financial risk is appreciated.

Attachments
:agw

and has obtained approval for added bed capacity under State licensure and under its Medicare certification, it may identify the new beds as a new rehabilitation unit for the first full 12-month cost reporting period during which the beds are used to furnish inpatient care. A unit that is comprised of some beds that were previously licensed and certified, and some new beds, will be recognized as a new rehabilitation unit only if the majority of beds are new. For the first cost reporting period in which a hospital seeks exclusion of a new rehabilitation unit, the hospital may provide a written certification that the inpatient population it intends the unit to serve meets the requirements of paragraph (c)(4)(iii)(A) of this section instead of showing that it has treated such a population during its most recent 12-month cost reporting period.

(2) *Expansion of excluded units.* If a hospital that has an excluded rehabilitation unit has obtained approval for added bed capacity, under State licensure and under its Medicare certification, and seeks to add the new beds to its existing excluded unit for the first full 12-month cost reporting period during which the new beds are used to furnish inpatient care, the hospital may provide a written certification that the inpatient population that the new beds are intended to serve meets the requirements of paragraph (c)(4)(iii)(A) of this section instead of showing that those beds were used to treat such a population during the unit's most recent 12 month cost reporting period.

(f) *Changes in the size of excluded units.* For purposes of exclusion from the prospective payment system under this section, the number of beds and square footage of each excluded unit will remain the same throughout each cost reporting period, and any change in the number of beds or square footage considered to be part of an excluded unit may be made only at the start of a cost reporting period.

6. In § 405.472, paragraph (d)(2)(i) is revised to read as follows:

§ 405.472 Conditions for payment under the prospective payment system.

* * * * *

(d) Medical review activities for hospitals paid under the prospective payment system.

* * * * *

(2) *DRG validation.* (i) The attending physician must, shortly before, at, or shortly after discharge (but before a claim is submitted), attest to the principal diagnosis, secondary diagnoses, and names of major procedures performed. The information must be in writing in the medical record. Below the diagnostic and procedural information, and on the same page, the following statement must immediately precede the physician's signature:

① I certify that the narrative descriptions of the principal and secondary diagnoses and the major procedures performed are accurate and complete to the best of my knowledge.

In addition, when the claim is submitted, the hospital must have on file a current signed acknowledgement from the attending physician that the physician has received the following notice:

② "Notice to Physicians: Medicare payment to hospitals is based in part on each patient's principal and secondary diagnoses and the major procedures performed on the patient, as attested to by the patient's attending physician by virtue of his or her signature in the medical record. Anyone who misrepresents, falsifies, or conceals essential information required for payment of Federal funds, may be subject to fine, imprisonment, or civil penalty under applicable Federal laws."

The acknowledgement must have been completed within the year prior to the submission of the claim.

* * * * *

7. Section 405.473 is amended by revising paragraphs (b)(6) and (c)(1), revising and redesignating paragraphs (c)(2) through (c)(6) as (c)(3) through (c)(7) respectively, and adding a new paragraph (c)(2) to read as follows:

§ 405.473 Basic methodology for determining Federal prospective payment rates.

* * * * *

(b) Federal rates for fiscal year 1984. * * *

(6) *Geographic classifications.* (i) For purposes of paragraph (b)(5) of this section, the following definitions apply:

(A) The term "region" means one of the nine census divisions, comprising the fifty States and the District of Columbia, established by the Bureau of the Census for statistical and reporting purposes.

(B) The term "urban area" means:

(*1*) A Metropolitan Statistical Area (MSA) or New England County Metropolitan Area (NECMA), as defined by the Executive Office of Management and Budget; or

(*2*) The following New England counties, which are deemed to be urban areas under section 601(g) of the Social Security Amendments of 1983 (Pub. L. 98–21, 42 U.S.C. 1395ww (note)): Litchfield County, Connecticut; York County, Maine; Sagadahoc County, Maine; Merrimack County, New Hampshire; and Newport County, Rhode Island.

(C) The term "rural area" means any area outside an urban area.

(D) The phrase "hospital reclassified as rural" means a hospital located in a county that was part of an MSA or NECMA, as defined by the Executive Office of Management and Budget, but is not part of an MSA or NECMA as a result of an Executive Office of Management and Budget redesignation occurring after April 20, 1983.

(ii) For hospitals within an MSA or NECMA that crosses census division boundaries, the following provisions apply:

(A) The MSA or NECMA is deemed to belong to the census division in which most of the hospitals within the MSA or NECMA are located.

(B) If a hospital would receive a lower Federal rate because most of the hospitals are located in a census division with a lower Federal rate than the rate applicable to the census division in which the hospital is located, the payment rate will not be reduced for any cost reporting period beginning before October 1, 1984.

(C) If an equal number of hospitals within the MSA or NECMA are located in each census division, such hospitals are deemed to be in the census division with the higher Federal rate.

* * * * *

(c) *Federal rates for fiscal years after Federal fiscal year 1984*—(1) *General rule.* HCFA will determine a national adjusted prospective payment rate, for each inpatient hospital discharge in a Federal fiscal year after fiscal year 1984 involving inpatient hospital services of a hospital in the United States subject to the prospective payment system under § 405.471, and will determine a regional adjusted prospective payment rate for such discharges in each region, for which payment may be made under Medicare Part A. Each such rate will be determined for hospitals located in urban or rural areas within the United States and within each such region respectively, as described in paragraphs (c)(2) through (c)(7) of this section.

(2) *Geographic classifications.* (i) For purposes of this paragraph, the following definitions apply:

(A) The term "region" means one of the nine census divisions, comprising the fifty States and the District of Columbia, established by the Bureau of the Census for statistical and reporting purposes.

(B) The term "urban area" means—

(1) A Metropolitan Statistical Area (MSA) or New England County Metropolitan Area (NECMA), as defined by the Executive Office of Management and Budget; or

ENCLOSURE II.

Enclosure III

QUALITY
UTILIZATION APPROPRIATENESS
STATE
PEER REVIEW
ORGANIZATION

ALABAMA QUALITY ASSURANCE FOUNDATION
SUITE 300, TWIN TOWERS EAST
236 GOODWIN CREST DRIVE
BIRMINGHAM, ALABAMA 35209
TELEPHONE (205) 942-0785

GENERAL MEMORANDUM #85-09

MEMO: ADMINISTRATORS AND CHIEFS OF STAFF OF ALL ALABAMA HOSPITALS

INFO: TOMMY MCDOUGAL/ALAHA; ED FARRELL/BRHC; MARY GREGORY/DHHS; AQAF BOARD OF DIRECTORS

FROM: JOHN W. MILLER, CHIEF EXECUTIVE OFFICER

DATE: JUNE 5, 1985

SUBJ: PHYSICIAN ATTESTATION STATEMENT/ACKNOWLEDGEMENT

ALABAMA QUALITY ASSURANCE FOUNDATION, INC.

I. This General Memorandum effective July 1, 1985, supercedes General Memorandum's #84-08 and #84-10.

II. The following information is presented as provided in HCFA Transmittal IM 85-2 (March 1985). Pages 40 through 44 of IM 85-2 are provided as references for the following instructions. References are identified by a circled number.

III. Effective with July 1, 1985 discharges, the hospital must maintain a "Notice To Physicians" on file separate from the Attestation Statement. The "Notice To Physicians" is at circle #1 on page 40. The "Notice" must be signed as indicated in circle #2. It is recommended that the acknowledgement be placed on the same sheet of paper immediately following the "Notice" and have the following or similar form:

ACKNOWLEDGEMENT

I ________________ the undersigned, acknowledge that I have
(Typed Full Name)
received the above notice.

____
Signature

____
Date

It should be noted that the "Acknowledgement" must be updated on October 1st of each year. The Foundation will accept "Acknowledgements" signed within fifteen (15) days of each October 1st as long as over one (1) year has not elapsed since signing of the previous year's "Acknowledgement". For discharges prior to July 1st, the procedures outlined in General Memorandum 84-08 and 84-10 are acceptable, i.e. the "Acknowledgement" may be in the medical record with the Attestation Statement. Prior to July 1, 1985, the "Acknowledgement" must exist, either in the medical record or in a separate file. After July 1st, the "Acknowledgement" must be maintained in a separate file updated on October 1st of each year.

IV. The Attestation Statement as shown at circle #3 must be included as described in paragraph (3)(a),(b),(c) and (d) on pages 41 and 42. (See circle #4). Note that paragraph (b) on page 41 requires that the attesting physician must sign and date any changes made to the diagnoses and procedures already attested to by the physician.

V. It Should be noted that physicians signature means "legal" signature. The Foundation's review personnel are instructed to accept the statement of responsible hospital personnel that the signature is a "legal" one (i.e., initials are not acceptable unless the hospital can document that the initials are the physician's "legal"signature normally used on documents such as wills, checks, etc.) (see circle #4, page 41).

VI. The responsibilities of the PRO are listed at circle #5 and will be carried out by the Foundation as listed. Your cooperation will be appreciated.

Attachment
:agw

(2) Policy Effective October 1, 1984.--The policy described below is effective October 1, 1984.

③ (a) The attending physician must, shortly before, at, or shortly after discharge (but before a claim is submitted), attest to the principal diagnosis, secondary diagnoses, and names of major procedures performed. The information must be in writing in the medical record; below the diagnostic and procedural information, and on the same page, the following statement must immediately precede the physician's signature: "I certify that the narrative descriptions of the principal and secondary diagnoses and the major procedures performed are accurate and complete to the best of my knowledge."

In addition, when the claim is submitted, the hospital must have on file a current signed acknowledgement from the attending physician that the physician has received the following notice:

① "Notice to Physicians: Medicare payment to hospitals is based in part on each patient's principal and secondary diagnoses and the major procedures performed on the patient, as attested to by the patient's attending physician by virtue of his or her signature in the medical record. Anyone who misrepresents, falsifies, or conceals essential information required for payment of Federal funds, may be subject to fine, imprisonment, or civil penalty under applicable Federal laws."

② The acknowledgement must have been completed within the year prior to the submission of the claim. The hospital must assure that the acknowledgements are updated October 1 of each year. The acknowledgement must be signed by the attending physician using his/her legal signature (i.e., initials are not acceptable) and must indicate that he/she has received the notice listed above. It would not be acceptable, for example, for the hospital to utilize a return receipt for certified mail as the "signed acknowledgement."

(b) The requirements effective October 1, 1984 are expected to be implemented in all hospitals on or before April 1, 1985. This allows sufficient time for the hospitals to issue the penalty notice to physicians, to receive the signed acknowledgements, and to revise the certification statements. During the transition period, the attending physicians must either sign the certification and penalty statement described in item a.(1) of Section 2050.4.A.3. before the claim is submitted or, if the physician signs the certification statement described in item a.(2) of Section 2050.4.A.3 the hospital must have on file the signed acknowledgement from the attending physician indicating that the penalty notice was received.

(c) Definitions

o Physician Attestation - The requirement that the physician attest to diagnostic and procedural information on each case.

o Certification statement - This is the statement which must immediately precede the physician's signature on each case.

o Penalty statement - Prior to October 1, 1984, the penalty statement was included on each case immediately following the certification statement.

o Notice to Physicians - Effective October 1, 1984, the hospital is required to send the annual notice to each physician with admitting privileges at its facility and retain on file a current signed acknowledgement of receipt of the notice from each physician.

④ (3) Physician Requirements.--

(a) Certification.--The certification statements described in items a.(1) and a.(2) of Section 2050.4.A.3 must immediately precede the attending physician's signature and the physician must date his/her signature. In order to meet the attestation requirements this signature must be in writing and the physician must use his/her legal signature (i.e., initials are not acceptable). It is also not acceptable to use rubber stamps, electronic signatures, or facsimile signatures. However, the description of the diagnoses and procedures does not need to be hand-written by the attending physician. It would be acceptable for the hospital to have the diagnoses and procedures machine generated or prepared in the medical records department, for example, as long as the attending physician agrees and signs his/her name to the certification. Note: The diagnosis designated as the principal diagnosis must be clearly identified as the principal diagnosis on the attestation document.

④ (b) Changes Subsequent to Attestation.--In rare instances, it may be necessary for changes to be made to the diagnoses and procedures attested to by the physician (e.g., the results of an autopsy may confirm a diagnosis that was not confirmed before the beneficiary's death).

In these cases, the codes may be changed, but the attending physician must countersign the narrative changes upon which the new coding is based. The physician must date his/her signature and countersignature, if any. When performing DRG validation the PRO is to assure that the attending physician countersigned any diagnostic/procedural changes.

④ (c) Group Practices.--The attending physician is required to attest to the diagnostic and procedural information for his/her cases. There is, however, some flexibility in this area with respect to physicians in a group practice. If the physicians have a system whereby they visit the "group's" patients on a regular rotation (e.g., they take turns visiting a particular hospital, and examine and prescribe treatment for all of the group's patients in that hospital on their day), the attending physician or his associates would be permitted to sign the attestation statement. The rationale for this is that the attending physician and the associates have been involved in the care and treatment of the patient. However, if the physicians of the group merely "cover" for one another on their days off, the associates would not be permitted to sign the attestation statement for the attending physician of record.

④ (d) Teaching Institutions.--In teaching institutions or situations where medical staff contribute significantly to the course of treatment, only the signature of the physician identified as the "attending physician" will be accepted for purposes of attestation. The "attending physician" is the physician listed on the medical chart as the physician responsible for the patient's care.

b. ⑤ Monitoring Compliance with Attestation Requirements.--

(1) Certification Statement.--The PRO is to monitor hospitals' compliance with the attestation requirements. The physician attestation is a condition of payment under PPS and must be present in the medical record for every claim. The physician attestation must consist of either the certification and penalty statement described in item a.(1) or the certification statement described in item a.(2) of Section 2050.4.A.3., as applicable.

⑤ (a) If it is determined by the PRO that the attending physician did not attest to the diagnoses and procedures before the Medicare claim was submitted or that the attestation was not in the required format (e.g., the penalty statement was not present), the PRO is to notify the hospital that the attestation requirement was not met. The PRO is not to monetarily penalize the hospital when a rare case (as identified below in item

b) is identified where the attestation did not occur. However, since the attestation is a requirement for payment, the hospital must still obtain the physician's attestation, although late, and provide a reasonable rationale for why the requirement was not met before claim submittal.

⑤ (b) To determine whether the lack of attestation is an isolated problem with an individual case, (i.e., a "rare" case), the PRO is to examine the results of all DRG validation, performed either onsite or during the course of other review. If the PRO determines that the lack of attestation is not an isolated problem and that the attestation is lacking for significant numbers of cases handled by particular physicians, 100 percent review of these physicians' cases is to be instituted and payment is to be denied for all claims where the attestation requirement was not met. (A significant number will equal 2.5 percent or 3 cases, whichever is greater.) The hospital would not be permitted to obtain the attestation at a later point in order to receive payment for these claims. Note: The hospital cannot bill the beneficiary for claims denied because the physician attestation requirements were not met.

⑤ (c) If a pattern of abuse by the hospital is detected (e.g., claims without physician attestation also contain DRG errors), the PRO is to deny claims where the attestation requirements are not met and not permit the hospital to obtain the physician's attestation at a later point in order to receive payment for these claims. In addition to denial of claims, the PRO will institute appropriate corrective action (e.g., making educational contacts, increasing sample size, recommending sanction action against the hospital, or referral to the Office of the Inspector General).

⑤ (2) Signed Acknowledgement.--The certification statement described in item a.(2) of Section 2050.4.A.3. requires the hospital to have on file a current signed acknowledgement from the attending physician that the physician received the penalty notice. The PRO is to monitor compliance with this requirement as described below.

⑤ (a) On a yearly basis, the PRO is to select a random sample of physicians with active admitting privileges at the provider. The random sample is to be selected using the sample size chart in the attached Sampling and Universe Review Instructions. The universe size is the number of physicians with active admitting privileges at the provider. The PRO is to examine the provider's file of signed acknowledgements of receipt of the penalty notice to determine whether a current (i.e., within the year prior to submission of the claim) signed acknowledgement was on file for each physician sampled.

⑤ (b) If a current signed acknowledgement is missing for any physician, the PRO is to issue retroactive denials for all claims submitted where that physician was the attending physician of record. The PRO will continue to deny claims for these physicians until the signed acknowledgement of receipt of the penalty notice is on file.

⑤ (c) In addition, if more than 2.5 percent or 3 of the signed acknowledgements (whichever is greater) for sampled physicians in a provider are missing or not current, the PRO is to examine that provider's files to determine whether a current signed acknowledegement is on file for each (i.e., 100 percent) of the physicians with active admitting privileges at that provider. The PRO will issue retroactive denials for all claims submitted where the signed acknowledgement from a physician was missing or not current and that physician was the attending physician of record. The PRO will continue to deny claims for each physician where the signed acknowledgement is missing until the signed acknowledgement of receipt of the penalty notice is on file for that physician.

4. ICD-9-Coding.--

a. DRG validation must be based upon accepted principles of coding practice and must be consistent with guidelines established for ICD-9-CM coding, and the UHDDS data element definitions. The PRO is not permitted to change these guidelines or institute new coding requirements which do not conform with established coding rules.

Coding procedures rely upon ICD-9-CM coding manual, second edition, September 1980. If earlier editions of coding manuals are used, the review coordinator must have errata one and two. Errata three, published by American Medical Records Association in August 1983, is not recognized by HCFA for DRG coding purposes.

b. In addition to verifying that accurate codes have been assigned to the conditions identified for billing purposes, the DRG validation procedure must establish that--

(1) The principal diagnosis assigned is, in fact, "the condition established after study to be chiefly responsible for occasioning the admission of the patient to the hospital for care";

(2) The secondary diagnoses identified represent all comorbidities and complications. The secondary diagnoses do not need to be listed in a particular sequence on the claim form as the GROUPER program will search through all secondary diagnoses listed on the claim form when assigning the appropriate DRG;

ENCLOSURE IV

QUALITY
AQAF
UTILIZATION APPROPRIATENESS
STATE
PEER REVIEW
ORGANIZATION

ALABAMA QUALITY ASSURANCE FOUNDATION
SUITE 300, TWIN TOWERS EAST
236 GOODWIN CREST DRIVE
BIRMINGHAM, ALABAMA 35209
TELEPHONE (205) 942-0785

GENERAL MEMORANDUM #85-09A
AMENDMENT/JUNE 14, 1985

MEMO: ADMINISTRATORS AND CHIEFS OF STAFF OF ALL ALABAMA HOSPITALS

INFO: TOMMY MCDOUGAL/ALAHA; ED FARRELL/BRHC; MARY GREGORY/DHHS; AQAF BOARD OF DIRECTORS

FROM: JOHN W. MILLER, CHIEF EXECUTIVE OFFICER

DATE: JUNE 14, 1985

SUBJ: PHYSICIAN ATTESTATION STATEMENT/ACKNOWLEDGEMENT

ALABAMA QUALITY ASSURANCE FOUNDATION, INC.

I. In response to HCFA Regional Office and IM 85-2 requirements, this General Memorandum amends the effective date of General memorandum #85-09. It also addresses hospital inquiries regarding the filing of signed physician acknowledgements of "Notice To Physicians". The requirements of 85-09 remain the same.

II. The following information is presented as provided in HCFA Transmittal IM 85-2 (March 1985). Pages 40 through 44 of IM 85-2 are provided as references for the following instructions. References are identified by a circled number.

III. Effective with April 1, 1985 discharges, the hospital must maintain a "Notice To Physicians" on file separate from the Attestation Statement. The "Notice To Physicians" is at circle #1 on page 40. The "Notice" must be signed as indicated in circle #2. Please note that the hospital must have on file a current signed Acknowledgement from the attending physician that the physician has received the penalty notice. This Acknowledgement is to be kept by the hospital. It is recommended that the acknowledgement be placed on the same sheet of paper immediately following the "Notice" and have the following or similar form:

((ENCLOSURE IV

General Memorandum #85-09A
Page 2.

June 14, 1985

ACKNOWLEDGEMENT

I________________the undersigned, acknowledge that I have
(Typed Full Name)
received the above notice.

____
Signature

____
Date

It should be noted that the "Acknowledgement" must be updated on October 1st of each year. The Foundation will accept "Acknowledgements" signed within fifteen (15) days of each October 1st as long as over one (1) year has not elapsed since signing of the previous year's "Acknowledgement". For discharges prior to April 1st, the procedures outlined in General Memorandum 84-08 and 84-10 are acceptable, i.e. the "Acknowledgement" may be in the medical record with the Attestation Statement. Prior to April 1, 1985, the "Acknowledgement" must exist, either in the medical record or in a separate file. After April 1st, the "Acknowledgement" must be maintained in a separate file updated on October 1st of each year.

It is also recommended that new staff physicians sign Acknowledgement Statements effective with the granting of staff privileges (i.e. do not wait for the October update).

IV. The Attestation Statement as shown at circle #3 must be included as described in paragraph (3)(a),(b),(c) and (d) on pages 41 and 42. (See circle #4). Note that paragraph (b) on page 41 requires that the attesting physician must sign and date any changes made to the diagnoses and procedures already attested to by the physician.

V. It Should be noted that physicians signature means "legal" signature. The Foundation's review personnel are instructed to accept the statement of responsible hospital personnel that the signature is a "legal" one (i.e., initials are not acceptable

ENCLOSURE IV

unless the hospital can document that the initials are the physician's "legal"signature normally used on documents such as wills, checks, etc.) (see circle #4, page 41).

VI. The responsibilities of the PRO are listed at circle #5 and will be carried out by the Foundation as listed. Your cooperation will be appreciated.

Attachment (See Attachments of GM #85-09 dated 06/05/85)
:agw

NOTE: Please place this Amendment with the General Memorandum #85-09 dated June 05, 1985.

Enclosure V

ALABAMA QUALITY ASSURANCE FOUNDATION
SUITE 300, TWIN TOWERS EAST
236 GOODWIN CREST DRIVE
BIRMINGHAM, ALABAMA 35209
TELEPHONE (205) 942-0785

STATE
PEER REVIEW
ORGANIZATION

GENERAL MEMORANDUM #85-18

MEMO: ADMINISTRATORS AND CHIEFS OF STAFF, ALL ALABAMA HOSPITALS

INFO: TOMMY MCDOUGAL/ALAHA; ED FARRELL/BRHC; MARY GREGORY/DHHS; AQAF BOARD OF DIRECTORS

FROM: JOHN W. MILLER, CHIEF EXECUTIVE OFFICER

DATE: AUGUST 09, 1985

SUBJ: PHYSICIAN ATTESTATION STATEMENTS

I. General Memorandum #85-09A made the implementation date of the separation of the Physician Attestation Statement from the Physician Penalty Statement effective April 1, 1985 discharges.

II. The attached Atlanta Regional Medical Review letter #13-85 received August 5, 1985 by the Foundation grants relief from the April 1, 1985 implementation date. The new implementation date is July 1, 1985 as was originally established by Foundation General Memorandum #85-09. This means that discharges prior to July 1, 1985 may have the Physician Attestation Statement and the Physician Penalty Clause both on the Face Sheet or the Physician Penalty Clause may be on file in the hospital. Effective July 1, 1985, the two statements must be separated and the Penalty Clause acknowledgement must be on file separately from the Attestation Statement on the Face Sheet.

III. The Regional Medical Review letter does not grant relief from the April 1, 1985 date for having the Physician Attestation Statement both signed and dated. Your cooperation is requested to insure that all Attestation Statements on discharges of April 1, 1985 or later have both the physician's signature and the date the Attestation was signed. It is suggested that these dates be added by the physicians as they sign current Attestation Statements.

IV. Your cooperation with the Foundation in its efforts to comply with the requirements placed on PROs is appreciated.

Attachment
:agw

DEPARTMENT OF HEALTH & HUMAN SERVICES

Health Care Financing
Administration

Region IV
101 Marietta Tower
Atlanta GA 30323

RECEIVED
AUG 05 1985

MEDICARE
MEDICAID

July 31, 1985

ATLANTA REGIONAL MEDICAL REVIEW LETTER NO. 13-85
(Of Interest to Peer Review Organizations)

SUBJECT: MEDICAL REVIEW TEAM MONITORING OF PHYSICIAN ATTESTATION STATEMENTS

Sec. 2050.4(3) of Transmittal IM-85-2, Peer Review Organization Manual, specifies two different timeframes for acceptable formats to be used in physician attestation requirements.

Policy effective Feb. 2, 1984 through Sept. 30, 1984 states that the combined attestation statement and penalty clause for each case must immediately precede the attending physician's signature.

Policy effective Oct. 1, 1984 and expected to be implemented in all hospitals on or before April 1, 1985 is that the attestation statement for each case must immediately precede the attending physician's signature. But the penalty clause acknowledgment is now separate. Instead, the hospital must have on file a current signed acknowledgment from the attending physician that the physician has received the penalty notice.

Because Transmittal IM-85-2, effective March 25, 1985, and specifying the expected implementation date of April 1, 1985, was not received timely by Peer Review Organizations (PRO's) and hospitals (few PRO's had received the transmittal by April 1 and several days were required to notify hospitals), the Regional Office Medical Review Team will accept (for the quarter April through June 1985 only) either format in its monitoring of PRO reviews. However, the attestation statement, in either format, must be properly executed to be acceptable.

The Regional Office has received numerous calls regarding the acceptable implementation date discussed above, as well as requests for clarification on what constitutes a legal signature and the definition of "a current signed acknowledgment."

A legal signature is the normal signature a physician uses when signing legal documents such as checks, wills, income tax returns, etc. Initials alone are not acceptable as a legal signature. One or two initials plus the last name written out are acceptable if that is the physician's normal signature in signing legal documents. At the same time, it is not necessary for the physician to write out every letter of every name unless that is the normal signature used in signing legal documents.

A current signed penalty clause acknowledgment, which must be updated annually on October 1, is required after October 1, 1984 and must, for payment purposes, be on file before the claim is submitted for payment.

E. Ronald Niswander
for George R. Holland
Regional Administrator
Health Care Financing Administration
Region IV

INDEX IV

INTERNAL HOSPITAL MEMORANDA AND LETTERS PERTAINING TO UTILIZATION REVIEW AND PHYSICIAN PRACTICE PATTERNS

S. R. GREENBERG, M.D., LTD.
HOSPITAL

Telephone

SIGMUND R. GREENBERG, M.D., F.A.C.P.

INTERNAL MEDICINE
ENDOCRINOLOGY - METABOLIC DISEASES

September 17, 1985

Mr. James Michie
c/o Senator John Heinz Office
Special Committee on Aging
U. S. Senate Rocm #S-D-G33
Washington, D.C. 20510

Dear Jim:

I am enclosing some documents which should open your eyes. Please call me if you have any questions about the enclosed.

Please also return these to me when you have finished with them
Kindest personal regards and

Very truly yours,

Sigmund R. Greenberg, M.D.

SRG/da
cc: file

Pennsylvania
Blue Shield

Camp Hill
Pennsylvania 17011

SEP 12 1985

Sigmund R. Greenberg, M.D., Ltd.

, PA

Dear Doctors:

As you may recall, we informed you of our clinical record request from the Hospital in November, 1984.

This request was generated as a result of a review of your statistics for intermediate and prolonged detention care hospital visits reported during 1982 and 1983.

After analyzing these records, as well as your current statistics, which reflected a decline in the number of intermediate and prolonged detention care visits reported, we have determined that no apparent overutilization exists at this time, and we are concluding our review.

Thank you for your cooperation.

Sincerely,

Emelie A. Sconing

Emelie A. Sconing
Manager - Private Business
Utilization Review

EAS:BR/el

Pennsylvania
Blue Shield

Medicare

Box 65
Camp Hill, PA 17011

1.717.763-3420

August 23, 1985

Sigmund R. Greenberg, M.D., Ltd.
PA

Re: Increased Charges

Dear Dr. Greenberg:

In August 1984 you were notified by letter dated August 24, 1984 of the provisions of the Deficit Reduction Act of 1984 (Public Law 98-369) relating to physician reimbursement. This law established a freeze on Medicare reimbursement for physician services, created a participation program, and prohibited nonparticipating physicians from raising their charges to Medicare beneficiaries. Under the law, a physician who knowingly and willfully increases his charges in violation of this prohibition is subject to assessments of up to double the amount of the violative charges, civil monetary penalties (up to $2,000 per violation), as well as exclusion from the Medicare program for up to five years.

Since you chose not to become a participating physician for the period October 1, 1984 through September 30, 1985, you are subject to the freeze on fees charged to Medicare beneficiaries and to the penalties if you violate the freeze. Physicians who chose to be Medicare nonparticipating physicians may continue to accept or decline assignment on a case-by-case basis. However, should a physician decide to accept assignment for all Medicare patients, he is not automatically considered to be a participating physician. The Medicare participating agreement enclosed with our August 24, 1984 letter, had to be signed by the physician and returned to us in order to become a Medicare participating physician. As a Medicare nonparticipating physician, the mandated fee freeze is applicable to billed charges for both assigned and non-assigned claims.

We have recently conducted a review of the claims for services rendered by you during the period January 1, 1985 to March 31, 1985. Billed charges for these dates of service were compared to your Level I customary charges which were calculated from services rendered during the base period, April 1, 1984 to June 30, 1984, for sampled procedures. Then, all charges identified during the monitored quarter as exceeding the customary charges, were researched against the actual billed charges from the base period. The billed charges which varied from your base period pattern of charges are identified as increased charges. It appears that the identified charges may be in violation of the fee freeze.

The enclosed report identifies all billed charges which exceeded your base period customary charges. Only the claims highlighted on the report identify the charges which appear to be in violation of the fee freeze. This report lists the date of service, the beneficiary name, the charge for the service, and the base period customary charge which we have on file.

We would appreciate your review of the information contained in the summary along with the enclosed copy of your base period charges. If you believe this information is in error, please provide us with a written explanation within fifteen (15) days of the date of this letter. We will review the information you present and any charges which were incorrectly identified will not be considered to be violations of the freeze.

If we do not receive a written explanation from you within this time period, we will be required to continue monitoring your billed charges which could result in our referral of this information to the Office of Inspector General for a determination in accordance with its civil monetary penalty and sanction authorities.

Sincerely,

Lois K Van Orden

Lois K. Van Orden
Manager - Medicare
Utilization Review

LKVO:BJK/tmm

Enclosure

I-15

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                                          P E N N S Y L V A N I A   B L U E   S H I E L D
RUN DATE    [illegible]                              PENNSYLVANIA                                                 PAGE     1
REPORT NO.  [illegible]-0A1          MEDICARE ORA BASE PERIOD LEVEL I DETAILS     FROM 04/84 06/84
   DR NUM        TS/PROC        LEV1     TOT NO    ABU    CHARGE      NO  CHARGE      NO  CHARGE      NO  CHARGE      NO

000013903        [illegible]     *            2             273.00       2
                 [illegible]     *            1             225.00       1
                 [illegible]     *            2             690.00       1  1065.00       1
                 [illegible]     *            1              15.00       1
                 [illegible]   110.00         1             110.00       3
                 [illegible]    45.00        61              55.00       8    45.00      53
                 [illegible]    60.00         9              45.00       1    60.00       8
                 [illegible]     *            1              65.00       1
                 [illegible]   110.00        41              45.00       2   110.00      32  115.00       7
                 [illegible]    45.00       762              45.00     653    47.00      82   70.00       2  135.00       5
                 [illegible]    70.00        63              70.00      61    75.00       2
                 [illegible]   100.00        19             100.00      11   110.00       8
                 [illegible]    50.00        19              90.00      10    65.00       9
                 80 93015        *            1             180.00       1
                 [illegible]     *            1              50.00       1
                 [illegible]     *            1              65.00       1
                 90 90620      110.00        27              95.00       1   110.00      24  115.00       2
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S. R. GREENBERG, M.D., LTD.

Telephone

SIGMUND R. GREENBERG, M.D., F.A.C.P.

INTERNAL MEDICINE
ENDOCRINOLOGY - METABOLIC DISEASES

August 26, 1985

Lois Van Orden, Manager
Medicare Utilization Review
c/o Pennsylvania Blue Shield
Box [illegible]
Camp Hill, Pa. 17011

Dear Miss Van Orden:

I am in receipt of your letter of August 23, 1985. If, after reading this letter, you have anymore questions in regard to the profile and/or billing policy, please contact me by phone and perhaps I can clarify it futher. Indeed, I tried calling you today, 8/26/85, but was unable to reach you. I left a message for you to call me back so that I could be a little bit more explicit in this particular letter, but my call was not returned.

I am a non-participating Medicare physician. I have historically increased my fee schedule regularly every six months for many years. As has been customary, this fee schedule was increased in the latter part of June, 1984, but in no way knowingly or willfully in violation of any law. There was no freeze in effect at that time and I was not aware that any freeze was anticipated. As a matter of fact, I had called Mr. Paul DiSantis, Medicare District Representative, concerning this increase before it was put through. He advised me to proceed with this since he knew of no law or restriction prohibiting it. As a matter of fact, Mr. DiSantis stated that Medicare had already processed an increase in profile for me which was to begin July 1, 1984, and that this information had already been entered in the computer.

The fee schedule increase, as enclosed, took place in the latter part of June, 1984, and was effective uniformly for all patients whether Blue Shield, Medicare, private insurance or no insurance. No fee alteration or increase has ensued since August of 1984 at which time our office was notified by Medicare of the new law (#98-369).

I do not believe, hence, that I am in violation of any law since the fee schedule that was initiated in the latter part of June was initiated before any freeze; was utilized for all patients irrespective of whether they were Medicare, Blue Shield or other and no increase has been made since I was notified of the law.

Perhaps, when you conducted the review of the period of Jan. 1, 1985 to March 31, 1985, and compared those to April 1 to June 30, 1984, the fact that my fees increased in the latter part of June, 1984, was not reflected in the April to June summary. I suppose that's the only way I can explain the altered charge interpretation as implied in your letter.

Page #2 Re: Medicare

If you do have further questions, please feel free to call upon me at any time. I would appreciate a phone call so that perhaps I could identify some problems more directly and answer any of your questions, but if you prefer, I would be delighted to answer you by mail.

Very truly yours,

Sigmund R. Greenberg, M.D., F.A.C.P.

SRG/da
cc: [illegible] (4)
cc: Mr. [illegible] Esq.
Attorney at Law

S. R. GREENBERG, M.D., LTD.

Telephone

SIGMUND R. GREENBERG, M.D., F.A.C.P.

INTERNAL MEDICINE
ENDOCRINOLOGY - METABOLIC DISEASES

September 17, 1985

Mr. James Michie
c/o Senator John Heinz Office
Special Committee on Aging
U. S. Senate Rocm #S-D-G33
Washington, D.C. 20510

Dear Jim:

I am enclosing some documents which should open your eyes. Please call me if you have any questions about the enclosed.

Please also return these to me when you have finished with them
Kindest personal regards and

Very truly yours,

Sigmund R. Greenberg, M.D.

SRG/da
cc: file

HOSPITAL

Chairman – Department of Medicine

June 11, 1984

. M.D.
M.D.
Co-Chairmen
Utilization Review Committee

I would rather practice medicine!!!

Gentlemen:

Recently the procedure for finalizing a decision to terminate a patient's stay with reference to third party payment has been changed. A case involving this problem has arisen today (June 8th) and is culminating in a series of activities on Friday afternoon. My own feeling is that it is unnecessary and inappropriate to ask Departmental Chairmen to be the final instrument of each of these decisions. The reason for having the Utilization Review Committee is to even out this process and, in cases of doubt, have the chart reviewed by one or more physician reviewers. Your Committee has done this well and in this case at least two physicians have reviewed such a chart and issued warning statements and final decision statements to the patient's family and to the attending -- why then is it necessary to ask the Departmental Chairman to additionally review such a chart and to personally notify the attending as additional backup?

My suggestion is that the Utilization Review Committee is well structured, well staffed for this purpose, and should be entirely backed by the medical staff and the administration. Routine matters of case termination by this Committee should stand on their own merit. Departmental Chairmen should not be involved in such cases unless some sort of a hearing process or further dispute arises, and the Departmental Chairman should not be required to notify attendings who have already been notified both on the chart and by letter.

An additional problem is the short time period between notification of termination and the fact of termination. During this brief time period the attending, I believe, has an obligation to review his management plans and to

Drs. &
Page Two
June 11, 1984

state the reasons for the hospitalization, some of which may not be covered in the chart. In order to accomplish this, a clear pathway for these communications is necessary and I'm not sure that it is uniformly understood and available to our staff.

My last suggestion is that we have a major educational process so that our entire staff is thoroughly familiar with the U.R. process. Everyone should be familiar with the "ground rules", have an opportunity to ask questions, and then I believe peer acceptance will be followed by peer pressure to make the syste work smoothly.

Regards,

M.D.

cc: Dr.
Dr.
bcc: ✓ Dr. Greenberg

HOSPITAL

PENNSYLVANIA

Chairman, Board of Trustees

FACHA President
M.D. Chief-of-Staff

October 3, 1984
Medicare #
Medical Record #
Hosp. Room #
Adm. Date 9-24-84

Mrs.
c/o

Dear Mrs.

The Utilization Review Committee of Hospital has reviewed your medical record and has determined that continued hospitalization in an acute care hospital is no longer medically necessary and/or appropriate. You no longer require 24 hour continuous attention of trained medical and paramedical personnel and further hospitalized care is no longer needed.

Your attending physician, Dr. S. Greenberg, has been contacted. The Hospital Administration and the Business Office have been notified of this decision. The Medicare program will cover your hospital stay for an additional 1 day from the date of this letter to allow you or your representative to make arrangements for transfer. Therefore, after October 4, 1984, additional expenses incurred during this admission will not be reimbursed under the Medicare Program of the Social Security Act.

This means that after October 4, 1984, you will be personally responsible for the payment of any charges incurred during your stay.

Sincerely yours.

M.D., Co-Chairman
Utilization Review Committee

Termination of care + coverage by medicare!

cc: Attending Physician
Social Work
(2) Business Office
Aetna Life & Casualty
Administration

UTILIZATION REVIEW
HOSPITAL

[illegible]

October 2, 1984

URGENT

A physician member of the Utilization Review Committee will be reviewing this patient's progress notes and chart within the next weekday in order to determine if the necessity for hospital level of care is documented on the chart.

IF, UPON RE-REVIEW, THE COMMITTEE FINDS THAT THE NEED FOR HOSPITAL LEVEL OF CARE IS NOT CLEARLY DESCRIBED IN THE HOSPITAL CHART, THE COMMITTEE WILL RECOMMEND TERMINATION OF INSURANCE BENEFITS. WE WILL INFORM YOU AND THE PATIENT AND THE BUSINESS OFFICE OF THE TERMINATION OF BENEFITS. THIS TERMINATION MEANS THAT ANY FUTURE EXPENSES MAY NOT BE COVERED BY THE PATIENT'S INSURANCE CARRIER IF THEY AGREE WITH THE COMMITTEE DETERMINATION.

> "Hospital level of care" is defined as that care which must be provided in a short term hospital. This means that certain services must be available to properly care for the patient. These services include, but are not limited to:
>
> 1. Physician staffing 24 hours a day
> 2. Laboratory services available 24 hours a day
> 3. Radiology services available 24 hours a day
> 4. Operating Room
> 5. Intensive monitoring personnel/devices
> 6. Continuous or intensive monitored treatment 24 hours a day

The need for continued hospitalization is indicated in the patient's hospital chart by changes in regimen, description of progression or regression of problems (i.e. changing clinical situation), or explanation of extenuating circumstances necessitating hospital care.

THIS LETTER IS MEANT TO BE OUR ONLY COMMUNICATION WITH YOU DIRECTLY, SO PLEASE DOCUMENT ON THE ORANGE STICKER, AS SOON AS POSSIBLE, IF THERE ARE EXTENUATING CIRCUMSTANCES THAT WE HAVE FAILED TO NOTICE.

Sincerely,

The Utilization Review Committee

UTILIZATION REVIEW
HOSPITAL

October 2, 1984

Mrs.
c/o

ADM: 9-24-84
ROOM:

Dear Mrs.

This letter is being sent to help you understand the Hospital Utilization Review process.

Third party insurance regulations require the hospital's Utilization Review Committee to review the care of all patients. This is done by reviewing the documentation on each patient chart. On occasion, a patient's chart reflects that present care may not require a "hospital level of care" and could be rendered at less expense in a different manner.

> "Hospital level of care" is defined as that care which must be provided in a short term hospital. This means that certain services must be available to properly care for the patient. These services include, but are not limited to:
>
> 1. Physician staffing 24 hours a day
> 2. Laboratory services available 24 hours a day
> 3. Radiology services available 24 hours a day
> 4. Operating Room
> 5. Intensive monitoring personnel/devices
> 6. Continuous or intensive monitored treatment 24 hours a day

YOUR CHART IS BEING REVIEWED NOW WITH THIS IN MIND.

If it is felt that your present care does not require a "hospital level of care", a further review will be made by another Committee member. These reviews are made by physician members of our Utilization Review Committee in order to verify whether or not your needs could be equally served at a non-acute level of care.

THE COMMITTEE URGES YOU AND YOUR FAMILY TO SPEAK WITH YOUR PHYSICIAN, AS HE IS THE ONLY ONE WHO CAN SUPPLY THE COMMITTEE WITH NEEDED DOCUMENTATION SUPPORTING ACUTE CARE. The Social Worker assigned to your case can also help with any plans that are needed to help in your care after your hospital stay.

Sincerely,

The Utilization Review Committee

cc: Attending Physician
Social Worker

AEP CRITERIA
FOR CONTINUED STAY REVIEW

A. Medical Services

1. Procedure in operating room that day.
2. Scheduled for procedure in operating room the next day, requiring preoperative consultation or evaluation.
3. Cardiac catheterization that day.
4. Angiography that day.
5. Biopsy of internal organ that day.
6. Thoracentesis or paracentesis that day.
7. Invasive CNS diagnostic procedure (e.g., lumbar puncture, cysternal tap, ventricular tap, pneumoencephalography) that day.
8. Any test requiring strict dietary control, for the duration of the diet.
9. New or experimental treatment requiring frequent dose adjustments under direct medical supervision.
10. Close medical monitoring by a doctor at least three times daily (observations must be documented in record).
11. Post-operative day for any procedure covered in numbers 1, or 3-7 above.

B. Nursing/Life Support services:

1. Respiratory care - intermittent or continuous respirator use and/or inhalation therapy (with chest PT, IPPB) at least thrice daily.
2. Parenteral therapy - intermittent or continuous IV fluid
3. Continuous vital sign monitoring, at least every 30 minutes, for at least four hours.
4. IM and/or SC injections at least twice daily.
5. Intake and output measurement.
6. Major surgical wound and drainage care (chest tubes, T-tubes, hemovacs, Penrose drains).
7. Close medical monitoring by nurse at least 3 times daily, under doctor's orders.

C. Patient Condition

Within 24 hours before day of review:
1. Inability to void or move bowels (past 24 hours) not attributable to neurologic disorder.

Within 48 hours before day of review:
2. Transfusion due to blood loss.
3. Ventricular fibrillation or ECG evidence of acute ischemia, as stated in progress note or in ECG report.
4. Fever at least 101 rectally (at least 100 orally), if patient was admitted for reason other than fever.
5. Coma - unresponsiveness for at least one hour.
6. Acute confusional state, within past 96 hours.
7. Acute hematologic disorders, significant neutropeni, anemia, thrombocytopenia, leukocytosis, erythrocytosis, or thrombocytosis, yielding signs or symptoms.
8. Progressive acute neurologic difficulties.

Within 14 days before day of review:
9. Occurrence of a documented, new acute myocardial infarction or new CVA (stroke).

"The rule Book"
"Bible" → may not deviate

REASON CODES - NON-ACUTE DAY

Physician Factor

Ph_1 = Unnecessary admission

Ph_2 = Premature admission

Ph_3 = Delay in ordering ancillary or consult

Ph_4 = Delay in ordering discharge

Hospital Factor

H_1 = Consult delay

H_2 = Clinical lab delay

H_3 = X-Ray delay

H_4 = Order Dx Support (EEG, EKG, Cat Scan, etc.)

H_5 = OR delay

H_6 = Social work service

Environment Factor

E_1 = Lack of nursing home beds

E_2 = Lack of other beds

E_3 = Inadequate home (no heat, no running water, poor sanitation, etc.)

Patient Factor

P_1 = Patient and family pressure

P_2 = Failure of patient to leave hospital even though discharge ordered

P_3 = Lack of adequate home care

NEW APPOINTMENTS (continued)

F. , M.D., Assistant Physician, Emergency Care Unit. Dr. eceived her M.D. at Medical College of Pa. and received additional training in Emergency Medicine at Allentown and at Emory University Grady Hospital, Atlanta. Letters of support have been written by Dr. and the Director of her training program at Emory University Medical School. Her application is also supported by Dr. C , Chief of the Emergency Care Unit. The applicant has her Boards in Emergency Medicine. The Credentials Committee voted affirmatively and the Executive Committee voted to recommend that the Board of Trustees appoint her for a provisional year as Assistant Physician, Emergency Care Unit and the granting of the requested privileges. There is an opening in the Manpower Plan.

G. , M.D., Assistant Physician, Family Practice. Dr. , already certified by the American Board of Family Practice, will be full time as Associate Director of the Family Practice Unit. His application is supported by Drs. and as well as from Dr. at Chestnut Hill Hospital. Dr. is a graudate of Pittsburgh and is currently studying law. His presence will be of great assistance in preparing the Family Practice Residency-Training Program for its February 1986 review by the Residency Review Board. The Executive Committee voted to recommend that the Board of Trustees appoint him for a provisional year as Assistant Physician, Family Practice Division and grant the requested privileges. This is consistent with the Manpower Plan.

V. COMMITTEE REPORTS

A. Antibiotic Review Committee - Metronidazol audit finished. Follow up planned in one year. Several third generation cephalosporins being considered for addition to the drug list.

B. Standards & Economies - Number of items considered at 6/12/85 meeting. No action items for the Executive Committee.

C. Tissue Committee - June 11, 1985, one case referred from Pathology involving a nephrectomy which is currently under study. Gastroscopy audit has been completed with no significant discrepencies. An audit of pyloric stenosis operations extending over 4 years and including 11 cases was conducted with no discrepencies found.

D. Utilization Review Committee - June 6, 1985 - discussions regarding Dr. S-4 already recorded in last month's minutes. As instructed, Drs. and met with Dr. S-4 with considerable discussion over a two hour period, with conclusions to be written.

me

S.R. GREENBERG, M.D., LTD.

PA
Telephone

SIGMUND R. GREENBERG, M.D., F.A.C.P.

INTERNAL MEDICINE
ENDOCRINOLOGY · METABOLIC DISEASES

January 22, 1985

answer to Jan 17 198

, M.D.
Chairman, Department of Medicine
Hospital

Dear

I received your note of January 17 that was written to Dr. in regard to some questions related to issues of utilization, etc.

I am especially interested in the Blue Cross denial days.

Although it is not exactly clear to me what the statistics mean and how they are derived, it appears that, up until the time I resumed my individual practice without Dr. the denial rate was higher. After separation from Dr. , it appears that the denial rate has been less.

Again, however, these statistics are unclear to me.

Certainly, having been here since 1956, I have shown my intent to work within the system and help as much as I can. If there is any clarification needed from me on these cases therefore, please let me know. I discussed this with by phone.

In addition, I think somehow it should be built into the system and the statistics the skew of patients that I see and really I see some of the most complicated medical problems that are around. That is, I don't see patients "off the street", but they are referred to me after they have seen multiple doctors and, by the time I see some of the patients, they are far from uncomplicated.

In any case, you can be sure that I would be willing to discuss any questions that arise regarding this aspect of the hospital Blue Cross patients whenever you desire and would be delighted to discuss them with you personally, etc. Again, I discussed this with Dr. . If any additional information is required, please contact me.

I hope to continue to practice the finest medicine possible which I feel is in the best interest of my patients, the community and the hospital. Best wishes for a happy and healthy year.

Very truly yours,

Sigmund R. Greenberg, M.D., F.A.C.P.

SRG/da
cc: Dr.
cc: Mr.

HOSPITAL

PA.

Julie c̄ Litigation

DATE: March 1, 1985 → more hassle!!!

TO: , M.D.
Chairman Executive Committee

FROM: . M.D.

RE: Follow-up of previous myocardial infarction study

You will recall that the Utilization Review Committee developed a large amount of data relative to the handling of myocardial infarction, which was subsequently evaluated by a subcommittee, and then the Executive Committee who in turn met with Dr. and Dr. to discuss the issues. A follow-up study was mandated and has only recently been completed.

Dr. Greenberg's myocardial infarction discharges from January thru September of 1984 produce only 3 cases. These cases were reviewed and no significant problems in management or length of stay were observed. One of the three was actually managed entirely by another physician, and each of the other two had been admitted or followed by a second physician in view of vacation schedules.

Review of January thru September '84 discharges of Dr. H showed a larger number of patients', whose average length of stay was 1.8 days longer than the overall length of stay for that diagnosis during the same time period. It would appear that the pattern of both physicians has demonstrated a marked decrease in the length of stay, with Dr. cases between 1981 and September of 1984 dropping from 18.4 to 17.1 to 12.9. During the same time periods, those attributed to Dr. Greenberg diminished from 21.8 to 19.5 to 16.3. The overall length of stay for the entire hospital during the same period was 14.8,13.2, and 11.1. It would appear, therefore, that significant changes in management have occurred and are beginning to approach those of the staff in general.

cc: Dr.
Dr. Greenberg

HOSPITAL

. PENNSYLVANIA

M.D.
Chairman – Department of Medicine

Allergy & Immunology
Cardiology
Dermatology
Endocrinology
SIGMUND R. GREENBERG, M.D.
Family Practice
Gastroenterology
Hematology
Infectious Disease
Internal Medicine
Metabolism
[illegible]
Ne
Pediatrics
Psychiatry
Pu
Rheumatology

January 17, 1985

, M.D.
Chairman, Medical Executive Committee
Co-Chairman, QA Committee
Hospital
, PA

Dear

In compliance with the requirement that departmental chairmen provide an annual update on previously identified problems regarding patient care within their department, I must forward an as yet incomplete report on Dr. Sigmund Greenberg. There are two issues that require updating.

The myocardial infarction study done by Utilization Review and forwarded to the QA and then to a special subcommittee mandated a re-audit. This re-audit was carried out but, unfortunately, was poorly timed since almost half of the period re-audited covered a time when Dr. Greenberg remained in association with Dr. . This study, I am told, is still in progress.

The issue of excessive days of hospital stay, which is centered around the data regarding Blue Cross denial days, does indeed stretch back over a time period. The most recent data covering the six months ending December '84 have just been provided. The table below identifies the number of days denied on the medical services as a whole, as well as that portion representing Dr. Greenberg's own cases. Unfortunately, these figures would suggest that his practice pattern differs significantly from the rest of the medical staff.

If additional information is required, I am certain that Dr. Greenberg or this office, through the Utilization Review Committee and Record Room, would be able to provide it.

Sincerely,

, M.D.

cc: Dr. Greenberg
(PERSONAL & CONFIDENTIAL)

UTILIZATION DATA - "DENIALS"

	1981-82	7-12/82 (6 mo)	1-6/83 (6 mo)	7-12/83 (6 mo)	7-12/84 (6 mo)	
Total Medical	57	25 (50)	32	39	44	av/35/6 mo
S.R.G.	14	9 (18)	11	8	12	av/10/6 mo = .38 cases/wk
Percent	24	36	33	20	27	av 28%

1/85

S.R. GREENBERG, M.D., LTD.

PA

Telephone

SIGMUND R. GREENBERG, M.D., F.A.C.P.

INTERNAL MEDICINE
ENDOCRINOLOGY - METABOLIC DISEASES

April 2, 1985

M.D.
Chairman, Department of Medicine

Dear

As per our conversation on 4/2/85, I appreciate our chat in regard to utilization review, etc. I think things are much clearer to me now and from my understanding with you, it is not the fact that the patient is complicated and very sick that demands he be in the hospital but the fact that the patient is in the hospital because therapy offered at home is not adequate or another physical problem or whatever demands the stay in the hospital — that the frequency of blood tests, intravenous infusions, etc. command necessity for hospitalization. In essence then, it is not - from what I can gather - the complexity of the situation that demands hospitalization but the necessity for frequent monitoring, therapeutic modalities, etc. that will demand continued hospital stay.

This is much clearer to me now and perhaps some of these problems can be made even clearer to the staff at the next medical meeting of the Department of Internal Medicine.

I appreciate talking to you about this in an informal way and, again, if there are any questions, I would be happy to discuss it again with you. I feel that my mix of patients with the complexity of problems they have does demand a different type of approach; however, since our conversation, I shall try to make this much clearer concerning the problem of necessity for hospitalization.

I have a strong suspicion and partial confirmation that the Utilization Committee reviews my cases in a different perspective with greater captiousness than they do cases of ~~other~~ physicians who may be more in question regarding their practice pattern. I hope that is not true; I hope everyone is being treated the same. Kindest personal regards and

forcing the issue

Very truly yours,

Srg

Sigmund R. Greenberg, M.D.

SRG/da
cc: o.c.
cc: M.D.
cc: M.D.
cc: M.D.
cc: M.D.
cc: Mr.
cc: Mr.
cc: Mr.

UTILIZATION REVIEW
HOSPITAL

. PA.

Retrospective review of pt c̄ denial [illegible]

DATE: May 20, 1985

TO: Dr. S. Greenberg

FROM:
Co-Chairmen Utilization Review Committee

RE: Blue Cross of Greater Philadelphia Inquiry;
Retrospective Review

PATIENT:

Admission Date: 08/10/84
Discharge Date: 08/15/84

The Utilization Review Committee has received a letter from Blue Cross in reference to the above named patient. A copy of this letter is ttached.

We would like you to supply any information you may have so that we can evaluate the Blue Cross decision that this case was over-utilized by 5 days.

Please respond in writing by 6/03/85 to the Utilization Office. Thank ou for your kind cooperation.

HOSPITAL: - Level III - Potential Short Procedure Unit (SPU/Outpatient) Cases

PATIENT NAME	CTF. NO.	ADMISSION DATE	DISCHARGE DATE	DX.	PX.	GROUP	LOS	# DAYS INAPPROPRIATE	ATTENDING PHYSICIAN	REASON DAYS QUESTIONED
		8/10/84	8/15/84			68000	5	5	S Greenberg	Our medical consultants are questioning this entire hospitalization as unnecessary. This procedure could have been done in the Short Procedure Unit.

Blue Cross
of Greater Philadelphia

1333 CHESTNUT STREET PHILADELPHIA PENNSYLVANIA 19107

July 30, 1985

M.D.
M.D.
Co-Chairmen, Utilization Review Committee
Hospital

PA

RE:
CTF NUMBER:
ADMISSION DATE: 08-10-84
DISCHARGE DATE: 08-15-84
DAYS DENIED: 5

Dear Drs.

Thank you for your response regarding the above-named case. Please note that both our consultants and your committee agree that there is five day(s) of over-utilization in this case.

We appreciate the time taken by you and the other Utilization Review Committee members in reviewing this case. Blue Cross feels that this type of in-house Peer Review contributes greatly to the optimum utilization of health care facilities.

If your hospital participates in the Advanced Utilization Review Program, no adjustments will be made and the claim will remain paid. However, the days denied will be used in the calculation of your denial rate. If your hospital does not participate in the Advanced Utilization Review Program, Blue Cross Adjustment Section will withdraw the entire payment made for this claim. If the entire stay has been disallowed, please prepare an outpatient claim for the covered services, and send it to our Outpatient Claims Department for processing. If the stay is only partially rejected, prepare a new claim based on the approved portion only and send it to us.

Sincerely,

Joanne Colantuno
Manager, Medical Review

JC:vbh/4260D

cc: Administrator
Attending Physician
Business Office
Blue Cross Adjustment Section

S.R. GREENBERG, M.D., LTD.
HOSPITAL

PA

Telephone

SIGMUND R. GREENBERG, M.D., F.A.C.P.

INTERNAL MEDICINE
ENDOCRINOLOGY · METABOLIC DISEASES

May 22, 1985

Utilization Review Committee
Hospital

Re:

Dear Fellows:

In regard to your letter requesting information relating to 's hospitalization from 8/10 to 8/15/84, this patient was admitted because of anorexia nervosa, amenorrhea and just a downhill course over three years. There were so many basic problems that we could not get to; it was necessary to stress test with insulin, Factrel, etc.

We kept her a minimum amount of time to get things initiated to find out what was going on and under no circumstances will I do insulin stress tests on an outpatient basis since constant supervision is necessary and I do not feel it is fair to ask me to be in attendance for 90 minutes while a patient has an insulin stress test as an outpatient in a short procedure unit.

The investigation that was outlined in the chart and what was done for her required hospital care under supervision of nurses and doctors in order to ascertain exactly her disease, what to do, etc. Indeed, enclosed is a copy of the discharge summary to reiterate the situation.

I hope this note is of use to you in your consideration of 's case. As you know, her mother is one of the nurses on the Intravenous team who is very helpful herself in allaying a lot of suspicion on 's part since the patient herself would never have tolerated this type of work-up or an insulin stress test on an outpatient basis.

Very truly yours,

SGreenberg

Sigmund R. Greenberg, M.D.

SRG/da
cc: o.c.

enc: hospital summary

S. R. GREENBERG, M.D., LTD.
HOSPITAL

PA

Telephone

SIGMUND R. GREENBERG, M.D., F.A.C.P.

INTERNAL MEDICINE
ENDOCRINOLOGY · METABOLIC DISEASES

answer to July 9, 1985 letter

July 11, 1985

M.D.
Chairman, Department of Medicine
Hospital

Dear

Thank you for your note of July 9th regarding our meeting with Dr. concerning the utilization review committee, etc. I would be happy to meet with the people in the utilization committee whenever they want as long as I am given enough notice to rearrange schedules, etc. Late in the afternoon is my best time and I would have more time to devote to discussion with them. Just let me know in advance and things will be arranged. If you or want to be there, that is fine with me.

On page two of your note, however, something isn't clear to me and I will quote it - "We identified the need to make clear to reviewers the reason for the patient being in the hospital independent of issues of academic importance or complexity of the patient's illness". It would seem to me that the purpose of the hospital and the treatment of the patient in the hospital is directly proportional to the complexity of the patient's illness and that a patient, with a very complex problem that requires a multitude of medical and/or surgical disciplines in relationship to integration with X-rays and laboratory tests, certainly deserves to be in the hospital. Hence, the complexity of a patient's illness to me would seem to be a justifiable reason for the patient to be in the hospital. If the hospital is not here to care for patients with very complicated and complex illnesses, then what is it here for?

In any case, this is why I guess we should have another meeting and I will be delighted to meet with you whenever you wish. If you identify problems in the interim, feel free to call me. Kindest personal regards and

Very truly yours,

Sig

Sigmund R. Greenberg, M.D.

SRG/da
cc: O.C.
cc: M.D.
cc:

HOSPITAL

PENNSYLVANIA

, M.D.
Chairman – Department of Medicine

Endocrinology
SIGMUND R. GREENBERG, M.D.

July 2, 1985

Sigmund R. Greenberg, M.D.
PA

re: Utilization

more non sense!

Dear Sig:

On June 27, Utilization Review asked me to review the chart of on It is evident that this 80 year old lady has a lot of trouble and there were many obstacles in the evaluation of her anemia. Your notes indicated plans to return her to the nursing home on Monday, and Utilization Review agreed with me that there is no need for further action at this point.

The purpose of this note is to suggest some specific ways that you could work better within the system. It is evident that the patient was really here for a long time and it may have been possible to shorten that stay. It is also evident that she could not be easily prepared and was taken multiple times before studies could be completed. The issue is communication. It would have been most useful if you had written a direct response to the Committee's inquiry which was placed in the chart on several occasions in the form of the orange sticker. At no point did I see it clearly expressed that "this patient needs to be in the hospital because." The next suggestion would be to discuss the patient's needs with those helping in the case and arrive at a decision as to exactly how much effort is required to pursue the diagnosis and what the end point would be. For example, a note that said "after discussion with the hematologist, we feel one more effort at sigmoidoscopy is necessary -- if it fails, she will be transferred to the nursing home and arrangements will be made for a study in two weeks."

As you see, I am trying to offer specific suggestions that will prevent the conflicts that arrive in your cases.

Regards.

Sincerely,

M.D.

PENNSYLVANIA BLUE SHIELD
BOX 65 CAMP HILL, PA. 17011
Beneficiaries living in Pennsylvania call toll free
TELEPHONE (800) 382-1274

EXPLANATION of MEDICARE BENEFITS

(KEEP THIS MEDICARE CLAIM NOTICE FOR YOUR RECORDS)

15226

PATIENT'S NAME	HEALTH INSURANCE CLAIM NUMBER/CONTROL NO	1 PROCEDURE CODE / NO SVCS — 2 WHEN FROM MO DAY TO MO DAY YEAR	SERVICE CODES PLC TYP	3 AMOUNT BILLED	4 AMOUNT APPROVED	5 AMOUNT APPLIED TO DEDUCTIBLE	6 CO-INSURANCE	7 MEDICARE PAYS 80% OF THIS AMOUNT	8 INPATIENT RADIOLOGY PATHOLOGY SERVICE PAID IN FULL	9 Withheld for Offset	10 MEDICARE PAID PATIENT	11 MEDICARE PAID PROVIDER	12 MEDICARE DOES NOT PAY FOR
		902800010613061333	1	90.00	29.20								THIS PROCEDURE FOR YOUR CONDITION
		902800010610061033	1	90.00	29.20								THIS PROCEDURE FOR YOUR CONDITION
		902600070504051033	1	266.00	204.40								ASG CLAIM SEE 4 ON BAC
		902800010611061133	1	90.00	29.20								THIS PROCEDURE FOR YOUR CONDITION
		902800010612061233	1	90.00	29.20								THIS PROCEDURE FOR YOUR CONDITION
		* CLAIMS TOTALS *		626.00	321.20	0.00	64.24	321.20	0.00	0.00	0.00	256.96	

YOUR CLAIM HAS BEEN SEPARATED TO EXPEDITE HANDLING. YOU WILL RECEIVE A SEPARATE NOTICE FOR THE OTHER SERVICES REPORTED.
IF YOU DID NOT KNOW THAT MEDICARE DOES NOT PAY FOR THIS MEDICAL SERVICE FOR YOUR CONDITION, YOU MAY REQUEST A REVIEW OF THIS DECISION. FOR ADDITIONAL INFORMATION SEE 'YOUR RIGHT TO A REVIEW' ON BACK.

Denied to from medical
payment

tion by other physicians or suppliers for similar services in this area during the base year.

The maximum amount of the charge we can consider under Medicare is shown as "Amount Approved" (Column 4) on the front side. The amount exceeding the "Amount Approved" is not payable by the beneficiary on assigned claims.

5. **YOUR RIGHT TO A REVIEW OF THE CASE**
If you have a problem or question about the way your claim was handled or about the amount paid, please get in touch with Pennsylvania Blue Shield, P.O. Box 65, Camp Hill, Pa. 17011. Telephone:

in the facility charge for dialysis.

20. The deductible amount has been adjusted because of a previous claim.

21. This claim has been forwarded to the Travelers Insurance Company, P.O. Box 395, Albany, N.Y. 12201. They will advise you of available benefits. Please send future claims directly to them.

ALWAYS SHOW THE PATIENT'S HEALTH INSURANCE CLAIM NUMBER WHEN WRITING ABOUT YOUR CLAIM.

1. IMPORTANT — YOU CAN USE THIS NOTICE:
   A. As a record of bills paid or denied. If you have sent in other medical expenses not shown on this form, you will receive a separate notice.
   B. To collect other insurance.

2. TIME LIMIT FOR FILING CLAIMS

For services received:	File claims by:
Oct. 1, 1981 - Sept. 30, 1982	Dec. 31, 1983
Oct. 1, 1982 - Sept. 30, 1983	Dec. 31, 1984
Oct. 1, 1983 - Sept. 30, 1984	Dec. 31, 1985

When a person could not file within these limits because of an error or delay caused by the Health Care Financing Administration or a Medicare Carrier or Intermediary, the time limit may be extended if the claim is filed within 6 months after the error is corrected.

3. HOW MUCH DOES MEDICARE PAY?

Medicare pays 80% of the charges in column 4 after the annual deductible has been satisfied. The annual deductible is now $75.

For services rendered prior to Oct. 1, 1982, Medicare pays 100% of the charges in column 8 for Radiology and Pathology services from a physician for a bed patient in a qualified hospital whether or not the annual deductible has been satisfied.

4. IF PAYMENT IS NOT BASED ON THE FULL AMOUNT BILLED

The amount Medicare may pay is limited by law to the lowest of:

A. Customary charge, i.e., the charge made by the physician or supplier in 50% of his billings for this service during the base year.

B. Prevailing charge, i.e., the charge made 75% of time by other physicians or suppliers for similar services in this area during the base year.

CODES FOR PLACE OF SERVICE

1. Office
2. Home
3. Inpatient Hospital
4. Skilled Nursing Facility
5. Outpatient Hospital
6. Independent Laboratory
7. Other

CODES FOR TYPE OF SERVICE

1. Medical care
2. Surgery (Includes Treatment of Fractures)
3. Consultation
4. Diagnostic X-ray
5. Diagnostic laboratory
6. Radiation therapy
7. Anesthesia
8. Assistance at surgery
9. Other medical service
0. Whole blood and packed red blood cells
A. Purchase of Durable Medical Equipment

REMARK CODES

1. The claim number shown on this claim was incorrect. On future claims, please use the number and letters exactly as shown on patient's Medicare card.
2. The maximum annual outpatient psychiatric benefit has been paid and no further benefits are payable.
3. Your claim and/or receipt for service furnished outside of Pennsylvania has been forwarded to the correct carrier for processing.
4. Monthly installment allowances for durable medical equipment will be made on the amount approved above. Your allowances will arrive shortly. It may be necessary to recertify continuing medical necessity of this equipment within the next 6 months. If so, you will be notified by letter.
5. The above allowance is an adjustment to a previous claim.
6. Medicare Part B considers 62.5 percent of allowed psychiatric charges up to $312.50 in a calendar year.
7. SSA records indicate that the beneficiary has never enrolled in Medicare Part B. Therefore, no payment can be made for this claim.
8. This claim has been separated to expedite handling. You will receive a separate notice for the other services reported.
9. The patient is not on SSA file.
10. We were unable to obtain information required to properly process this claim. Therefore, this claim was processed on the basis of the information reported.
11. The name shown on this claim was incorrect. On future claims, please use the exact name as shown on patient's Medicare card.
12. Medicare does not pay for pre/post operative care separately from surgery.
13. If you did not know that Medicare does not pay for this medical service for the patient's condition, you may request a review of this decision. (See Item 5)
14. The Medicare Part B Payment shown above was paid to the patient as a refund.
15. The payment replaces a previously issued payment.
16. This claim has been forwarded to the Oklahoma Department of Public Welfare for handling. They will advise you of available benefits.
17. Part B allows up to $500 annual physical therapy expenses ($100 for services prior to Jan. 1, 1982).
18. Payment withheld due to a prior overpayment.
19. Usual and ordinary physician services for maintenance or training dialysis are not covered as a separate service under Medicare Part B. These services may be covered, however, when included in the facility charge for dialysis.
20. The deductible amount has been adjusted because of a previous claim.

Utilization Committee

HOSPITAL

PENNSYLVANIA

President
M.D., Chief-of-Staff

Chairman, Board of Trustees

DATE: 7/1/85

TO: MEDICAL STAFF

FROM: M.D.
Co-Chairman, DRG Committee

SUBJ: DRG Reports - March and April 1985

We have enclosed copies of the CMS 302 report for the months of March and April, 1985 as well a cumulative report for the months of January, Febuary and March. These are the same reports you received from previous months and should give you some details regarding DRG assignment--length of stay compared to the federal average and cost variance indicates the estimated difference between hospital cost and reimbursement received for that particular case. These reports only represent your Medicare patients discharged in that time frame.

illustration of the computer
printout to show how much
you "cost" hospital →
the expense of this operation would
pay for several full time investigators
in a scientific endeavor !

Greenberg, S.

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CS302E    PART-A  (MC AND MA CASES ONLY)         PROFIT/LOSS ANALYSIS BY PHYSICIAN AND DRG          (DETAIL REPORT)          PAGE      1
                           HOSPITAL                  APR 1985     (PROCESSED: 06-17-85 AT  3:48 P.M.)
            DISCH.
PHYS. DRG STATUS    LOS                               TOTAL       HOSPITAL      HOSPITAL         CHARGE            COST            REFERENCE
                                                    REIMBURSE      CHARGE         COST          VARIANCE         VARIANCE   AGE    NUMBER
      ***** MEDICARE NORMAL CASES

      012 DEGENERATIVE DISORDER, MEDICAL
      (31.0000-OUTLIER THRESH   9.4000-DRG GMEAN   1.1020-DRG WT    2728.51-HSP PORT     904.79-FED PORT   3619.17-FED RATE)
          ROUTINE     4
                                                    3633.30       2263.00       1253.84         1370.30          2379.46    78
      012 TOT:        4
                                                    3633.30       2263.00       1253.84         1370.30          2379.46               1-PTS
-------------------------------------------------------------------------------------------------------------------------------------
      015 SPECIFIC CEREBROVASCULAR DISORDER, W PRINC DX OF TRANSIENT ISCHEMIC ATTACK, MEDICAL
      (24.0000-OUTLIER THRESH   5.6000-DRG GMEAN    .6604-DRG WT    1635.13-HSP PORT     542.22-FED PORT   2168.87-FED RATE)
          ROUTINE     6
                                                    2177.35       2680.00       1509.33         (502.65)          668.02    76
      015 TOT:        6
                                                    2177.35       2680.00       1509.33         (502.65)          668.02               1-PTS
-------------------------------------------------------------------------------------------------------------------------------------
      089 SIMPLE PNEUMONIA AND/OR PLEURISY, W AGE 18-69 W CC  OR AGE 70+, MEDICAL
      (31.0000-OUTLIER THRESH   8.5000-DRG GMEAN   1.0914-DRG WT    2702.27-HSP PORT     896.09-FED PORT   3584.35-FED RATE)
          S.N.F.      8
                                                    3598.36       3670.00       2125.02          (71.64)         1473.34    85
      089 TOT:        8
                                                    3598.36       3670.00       2125.02          (71.64)         1473.34               1-PTS
-------------------------------------------------------------------------------------------------------------------------------------
      121 CIRCULATORY DISORDER WITH AMI, DISCHARGED ALIVE, WITH CARDIOVASCULAR COMPLICATIONS ,MEDICAL
      (34.0000-OUTLIER THRESH  11.9000-DRG GMEAN   1.8454-DRG WT    4569.14-HSP PORT    1515.16-FED PORT   6060.63-FED RATE)
          ROUTINE    16
                                                    6084.30       7894.00       4472.34        (1809.70)         1611.96    86
      121 TOT:       16
                                                    6084.30       7894.00       4472.34        (1809.70)         1611.96               1-PTS
-------------------------------------------------------------------------------------------------------------------------------------
      122 CIRCULATORY DISORDER WITH AMI, DISCHARGED ALIVE, WO CARDIOVASCULAR COMPLICATIONS,MEDICAL
      (32.0000-OUTLIER THRESH   9.8000-DRG GMEAN   1.3509-DRG WT    3344.78-HSP PORT    1109.15-FED PORT   4436.60-FED RATE)
          ROUTINE    16
                                                    4453.93       9192.00       5082.38        (4738.07)         (628.45)   72
      122 TOT:       16
                                                    4453.93       9192.00       5082.38        (4738.07)         (628.45)              1-PTS
-------------------------------------------------------------------------------------------------------------------------------------
      127 HEART FAILURE AND/OR SHOCK, MEDICAL
      (30.0000-OUTLIER THRESH   7.8000-DRG GMEAN   1.0300-DRG WT    2550.24-HSP PORT     845.68-FED PORT   3382.71-FED RATE)
          S.N.F.     23                             3395.92      12288.00       6572.78        (8892.08)        (3176.86)   80
          ROUTINE     6                             3395.92       3464.00       1863.34          (68.08)         1532.58    68
      127 TOT:       29
          AVG:     14.5                             6791.84      15752.00       8436.12        (8960.16)        (1644.28)              2-PTS
                                                    3395.92       7876.00       4218.06        (4480.08)         (822.14)
-------------------------------------------------------------------------------------------------------------------------------------
      132 ATHEROSCLEROSIS, AGE 0-69 W CC  OR AGE 70+, MEDICAL
      (29.0000-OUTLIER THRESH   6.7000-DRG GMEAN    .9087-DRG WT    2249.90-HSP PORT     746.08-FED PORT   2984.33-FED RATE)
          ROUTINE     8
                                                    2995.98       4061.00       2241.37        (1065.02)          754.61    66
      132 TOT:        8
                                                    2995.98       4061.00       2241.37        (1065.02)          754.61               1-PTS
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CS302E    PART-A  (MC AND MA CASES ONLY)              PROFIT/LOSS ANALYSIS BY PHYSICIAN AND DRG          (DETAIL REPORT)        PAGE    2
                          HOSPITAL                          APR 1985     (PROCESSED: 06-17-85 AT  5:48 P.M.)
         DISCH.                                              TOTAL       HOSPITAL      HOSPITAL        CHARGE           COST               REFERENCE
PHYS. DRG STATUS   LOS                                      REIMBURSE     CHARGE        COST          VARIANCE        VARIANCE   AGE      NUMBER
      ***** MEDICARE NORMAL CASES

      140 ANGINA, MEDICAL
      (21.0000-OUTLIER THRESH    5.5000-DRG GMEAN     .7470-DRG WT    1849.55-HSP PORT     613.32-FED PORT    2453.28-FED RATE)
          ROUTINE    9                                   2462.87      4535.00      2537.57        (2072.13)          (74.70)  69
      140 TOT:       9                                   2462.87      4535.00      2537.57        (2072.13)          (74.70)                1-PTS
      ---------------------------------------------------------------------------------------------------------------------------------------------
      217 WOUND DEBRIDE AND/OR GRAFT (OTHER THAN HAND) FOR MUSCULOSKELETAL SYS AND/OR CONNECT TISSUE DISORD
      (35.0000-OUTLIER THRESH   13.1000-DRG GMEAN    2.2587-DRG WT    5592.45-HSP PORT    1854.50-FED PORT    7417.98-FED RATE)
          ROUTINE    9                                   7446.95      3980.00      2242.22         3466.95          5204.73   82
      217 TOT:       9                                   7446.95      3980.00      2242.22         3466.95          5204.73                 1-PTS
      ---------------------------------------------------------------------------------------------------------------------------------------------
      277 CELLULITIS, W AGE 18-69 W CC  OR AGE 70+, MEDICAL
      (30.0000-OUTLIER THRESH    8.3000-DRG GMEAN     .8771-DRG WT    2171.66-HSP PORT     720.14-FED PORT    2880.55-FED RATE)
          ROUTINE   16                                   2891.80      8896.00      4865.09        (6004.20)        (1973.29)  75
      277 TOT:      16                                   2891.80      8896.00      4865.09        (6004.20)        (1973.29)                 1-PTS
      ---------------------------------------------------------------------------------------------------------------------------------------------
      397 COAGULATION DISORDER, MEDICAL
      (29.0000-OUTLIER THRESH    6.7000-DRG GMEAN     .9761-DRG WT    2416.79-HSP PORT     801.42-FED PORT    3205.69-FED RATE)
          ROUTINE   11                                   3218.21      3834.00      2325.50         (615.79)          892.71   74
      397 TOT:      11                                   3218.21      3834.00      2325.50         (615.79)          892.71                  1-PTS
      ---------------------------------------------------------------------------------------------------------------------------------------------

      ***** MEDICARE NORMAL CASES TOTALS:
                    132                                 45754.89     66757.00     37090.78       (21002.11)         8664.11                12-PTS

      ***** MEDICARE NORMAL CASES AVERGS:
                    11.0                                 3812.91      5563.08      3090.90        (1750.17)          722.01
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      CASES TOTALS:
                    132                                 45754.89     66757.00     37090.78       (21002.11)         8664.11                12-PTS

      CASES AVERGS:
                    11.0                                 3812.91      5563.08      3090.90        (1750.17)          722.01
          DISCH                                          TOTAL        HOSPITAL      HOSPITAL       CHARGE           COST
PHYS. DRG STATUS   LOS                                   REIMBURSE    CHARGE        COST           VARIANCE         VARIANCE  AGE  NUMBER
      **** MEDICARE NORMAL CASES
      076 MINOR CHEST AND/OR OTHER RESPIRATORY O.R. PROC, W CC
      [illegible]
          ROUTINE   23                                   6112.32      13380.00      [illegible]    [illegible]      [illegible]
      [illegible]
      121 CIRCULATORY DISORDER WITH AMI, DISCHARGED ALIVE, WITH CARDIOVASCULAR COMPLICATIONS, MEDICAL
      (34.0000-OUTLIER THRESH  11.9000-DRG GMEAN    1.8454-DRG WT     4569.14-HSP PORT    1515.16-FED PORT    6060.63-FED RATE)
          ROUTINE   23                                   6084.30      10190.00      5821.50        (4105.70)        262.80   76
          ROUTINE   16                                   6084.30      [illegible]
      [illegible]   39
          AVG:      19.5                                 6084.30      8903.50       4982.82        (2819.20)        1101.48
      140 ANGINA, MEDICAL
      (21.0000-OUTLIER THRESH   5.5000-DRG GMEAN   [illegible]
          ROUTINE    6                                   2462.87      2995.00       1555.63        (532.13)         907.24   69
      [illegible]    6                                   2462.87      [illegible]
      243 BACK DISORDER, MEDICAL
      (30.0000-OUTLIER THRESH   7.5000-DRG GMEAN    .7473-DRG WT     1850.29-HSP PORT     613.57-FED PORT    2454.27-FED RATE)
          ROUTINE   14                                   2463.86      7730.00       4237.81        (5266.14)        (1773.95)  75   000
      243 TOT:      14                                   2463.86      7730.00       4237.81        (5266.14)        (1773.95)         1-PTS
      449 POISONING AND/OR TOXIC EFFECTS OF DRUGS, AGE 18-69 W CC  OR AGE 70+, MEDICAL
      (28.0000-OUTLIER THRESH   5.6000-DRG GMEAN    .7255-DRG WT     1796.31-HSP PORT     595.67-FED PORT    2382.67-FED RATE)
          S.N.F.     9                                   2391.98      6164.00       3150.14        (3772.02)        (758.16)   89
      449 TOT:       9                                   2391.98      6164.00       3150.14        (3772.02)        (758.16)          1-PTS
      ----------------------------------------------------------------------------------------------------------------------------
      ***** MEDICARE NORMAL CASES TOTALS:
                    91                                   25599.63     48076.00      26193.97       (22476.37)       (594.34)          6-PTS
      ***** MEDICARE NORMAL CASES AVERGS:
                  15.2                                   4266.61      8012.67       4365.66        (3746.06)        (99.05)
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C8302E    PART-B  (MC AND MA CASES ONLY)    OUTLIER PROFIT/LOSS ANALYSIS BY PHYSICIAN AND DRG       (DETAIL REPORT)         PAGE     2
                        HOSPITAL                           MAR 1985      (PROCESSED: 06-10-85 AT 6:51 P.M.)

          DISCH.             DAYS' WAGE-ADJ  OUTLIER      TOTAL      HOSPITAL     HOSPITAL      CHARGE          COST              REFERENCE
PHYS. DRG STATUS      LOS    OVER  THRESHLD  PAYMENT    REIMBURSE     CHARGE        COST       VARIANCE       VARIANCE   AGE     NUMBER
      ***** MEDICARE OUTLIER CASES

      087 PULMONARY EDEMA AND/OR RESPIRATORY FAILURE, MEDICAL
      (30.0000-OUTLIER THRESH   7.7000-DRG GMEAN   1.5368-DRG WT   13805.06-HSP PO[illegible]  1266.78-FED PORT   5047.13-FED RATE)

          S.N.F.       31     1                  98.32      5165.16     34486.00     16559.88     (29320.84)     (11394.72)  92

      087 TOT:         31     1                  98.32      5165.16     34486.00     16559.88     (29320.84)     (11394.72)          1-PTS
      -----------------------------------------------------------------------------------------------------------------------------
      ***** MEDICARE OUTLIER CASES TOTALS:
                       31     1                  98.32      5165.16     34486.00     16559.88     (29320.84)     (11394.72)          1-PTS
      -----------------------------------------------------------------------------------------------------------------------------


                                                                                                  (DETAIL REPORT)         PAGE     3
                                                     PROFIT/LOSS ANALYSIS BY PHYSICIAN AND DRG
C8302E    PART-C  (MC AND MA CASES ONLY)                MAR 1985      (PROCESSED: 06-10-85 AT 6:51 P.M.)
                        HOSPITAL                                                                                          REFERENCE
                                                                     HOSPITAL     HOSPITAL      CHARGE          COST              NUMBER
          DISCH.             DAYS  WAGE-ADJ  OUTLIER      TOTAL       CHARGE        COST       VARIANCE       VARIANCE   AGE
PHYS. DRG STATUS      LOS    OVER  THRESHLD  PAYMENT    REIMBURSE
                                                                                                                                  7-PTS
      CASES TOTALS:   122     1                  98.32     30764.79     82562.00     42753.85     (51797.21)     (11989.06)

      CASES AVERGS:  17.4                                   4394.97     11794.57      6107.69      (7399.60)      (1712.72)
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58-30

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CS302E    PART-A  (MC AND MA CASES ONLY)          PROFIT/LOSS ANALYSIS BY PHYSICIAN AND DRG                (DETAIL REPORT)           PAGE     1
                          HOSPITAL          JAN - MAR 1985     (PROCESSED: 06-11-85 AT 12:20 P.M.)
          DISCH.
PHYS. DRG STATUS    LOS                              TOTAL         HOSPITAL      HOSPITAL        CHARGE           COST               REFERENCE
                                                     REIMBURSE     CHARGE        COST            VARIANCE         VARIANCE  AGE      NUMBER
--       ***** MEDICARE NORMAL CASES

         014 SPECIFIC CEREBROVASCULAR DISORDER, WO PRINC DX OF TRANSIENT ISCHEMIC ATTACK, MEDICAL
         (32.0000-OUTLIER THRESH   9.9000-DRG GMEAN   1.3386-DRG WT    3314.32-HSP PORT    1099.05-FED PORT   4396.20-FED RATE)
             ROUTINE    15
                                                     4413.37       7344.00       3991.04         (2930.63)        422.33   79
         014 TOT:       15                           4413.37       7344.00       3991.04         (2930.63)        422.33             1-PTS
         ------------------------------------------------------------------------------------------------------------------------------
         016 NON SPECIFIC CEREBROVASCULAR DISORDER, W CC , MEDICAL
         (29.0000-OUTLIER THRESH   7.4000-DRG GMEAN    .8503-DRG WT     2105.31-HSP PORT     698.14-FED PORT   2792.54-FED RATE)
             ROUTINE    10
                                                     2803.45       4872.00       2754.55         (2068.55)         48.90   95
         016 TOT:       10                           2803.45       4872.00       2754.55         (2068.55)         48.90             1-PTS
         ------------------------------------------------------------------------------------------------------------------------------
         017 NON SPECIFIC CEREBROVASCULAR DISORDER, WO CC , MEDICAL
         (29.0000-OUTLIER THRESH   7.2000-DRG GMEAN    .8305-DRG WT     2056.28-HSP PORT     681.88-FED PORT   2727.51-FED RATE)
             ROUTINE    13
                                                     2738.16       6132.00       3473.89         (3393.84)        (735.73)  71
         017 TOT:       13                           2738.16       6132.00       3473.89         (3393.84)        (735.73)           1-PTS
         ------------------------------------------------------------------------------------------------------------------------------
         066 EPISTAXIS, MEDICAL
         (15.0000-OUTLIER THRESH   3.7000-DRG GMEAN    .4073-DRG WT     1008.46-HSP PORT     334.41-FED PORT   1337.65-FED RATE)
             ROUTINE     8
                                                     1342.87       3322.00       1931.55         (1979.13)        (588.68)  88
         066 TOT:        8                           1342.87       3322.00       1931.55         (1979.13)        (588.68)           1-PTS
         ------------------------------------------------------------------------------------------------------------------------------
         076 MINOR CHEST AND/OR OTHER RESPIRATORY O.R. PROC, W CC
         (33.0000-OUTLIER THRESH  10.6000-DRG GMEAN   1.8539-DRG WT     4590.18-HSP PORT    1522.14-FED PORT   6088.54-FED RATE)
             ROUTINE    23
                                                     6112.32      13380.00       7284.75         (7267.68)       (1172.43)  76
         076 TOT:       23                           6112.32      13380.00       7284.75         (7267.68)       (1172.43)           1-PTS
         ------------------------------------------------------------------------------------------------------------------------------
         082 NEOPLASM OF RESPIRATORY SYSTEM, MEDICAL
         (29.0000-OUTLIER THRESH   7.4000-DRG GMEAN   1.1282-DRG WT     2793.38-HSP PORT     926.30-FED PORT   3705.21-FED RATE)
             ROUTINE    22
                                                     3719.68       9309.00       5159.17         (5589.32)       (1439.49)  75
         082 TOT:       22                           3719.68       9309.00       5159.17         (5589.32)       (1439.49)           1-PTS
         ------------------------------------------------------------------------------------------------------------------------------
         121 CIRCULATORY DISORDER WITH AMI, DISCHARGED ALIVE, WITH CARDIOVASCULAR COMPLICATIONS ,MEDICAL
         (34.0000-OUTLIER THRESH  11.9000-DRG GMEAN   1.8454-DRG WT     4569.14-HSP PORT    1515.16-FED PORT   6060.63-FED RATE)
             ROUTINE    23
             ROUTINE    16                           6084.30      10190.00       5821.50         (4105.70)        262.80   76
                                                     6084.30       7617.00       4144.14         (1532.70)       1940.16   80
         121 TOT:       39                          12168.60      17807.00       9965.64         (5638.40)       2202.96             2-PTS
             AVG      19.5                           6084.30       8903.50       4982.82         (2819.20)       1101.48
         ------------------------------------------------------------------------------------------------------------------------------
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669 59 108

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CS302E    PART-A  (MC AND MA CASES ONLY)        PROFIT/LOSS ANALYSIS BY PHYSICIAN AND DRG           (DETAIL REPORT)           PAGE     2
                        HOSPITAL              JAN - MAR 1985     (PROCESSED: 06-11-85 AT 12:20 P.M.)
           DISCH.                                       TOTAL         HOSPITAL      HOSPITAL        CHARGE           COST              REFERENCE
PHYS. DRG  STATUS    LOS                              REIMBURSE        CHARGE         COST         VARIANCE        VARIANCE    AGE     NUMBER
      ***** MEDICARE NORMAL CASES

      127 HEART FAILURE AND/OR SHOCK, MEDICAL
      (30.0000-OUTLIER THRESH   7.8000-DRG GMEAN    1.0300-DRG WT     2550.24-HSP PORT     845.68-FED PORT   3382.71-FED RATE)
          ROUTINE    23                               3395.92      11713.00       6412.15      (8317.08)       (3016.23)  84
      127 TOT:       23                               3395.92      11713.00       6412.15      (8317.08)       (3016.23)                1-PTS
      ----------------------------------------------------------------------------------------------------------------------------------
      130 PERIPHERAL VASCULAR DISORDER, AGE 0-69 W CC  OR AGE 70+, MEDICAL
      (29.0000-OUTLIER THRESH   7.1000-DRG GMEAN     .9545-DRG WT     2363.30-HSP PORT     783.69-FED PORT   3134.75-FED RATE)
          ROUTINE    19                               3146.99       8252.00       4676.12      (5105.01)       (1529.13)  75
      130 TOT:       19                               3146.99       8252.00       4676.12      (5105.01)       (1529.13)                1-PTS
      ----------------------------------------------------------------------------------------------------------------------------------
      135 CONGENITAL AND/OR VALVULAR DISORDER, W AGE 18-69 W CC  OR AGE 70+, MEDICAL
      (28.0000-OUTLIER THRESH   6.1000-DRG GMEAN     .9819-DRG WT     2431.15-HSP PORT     806.19-FED PORT   3224.74-FED RATE)
          ROUTINE    13                               3237.34       5128.00       2996.17      (1890.66)         241.17   74   00C
      135 TOT:       13                               3237.34       5128.00       2996.17      (1890.66)         241.17                 1-PTS
      ----------------------------------------------------------------------------------------------------------------------------------
      140 ANGINA, MEDICAL
      (21.0000-OUTLIER THRESH   5.5000-DRG GMEAN     .7470-DRG WT     1849.55-HSP PORT     613.32-FED PORT   2453.28-FED RATE)
          ROUTINE     6                               2462.87       2995.00       1555.63       (532.13)         907.24   69
      140 TOT:        6                               2462.87       2995.00       1555.63       (532.13)         907.24                 1-PTS
      ----------------------------------------------------------------------------------------------------------------------------------
      141 SYNCOPE AND/OR COLLAPSE, AGE 0-69 W CC  OR AGE 70+, MEDICAL
      (21.0000-OUTLIER THRESH   5.0000-DRG GMEAN     .6408-DRG WT     1586.60-HSP PORT     526.13-FED PORT   2104.50-FED RATE)
          ROUTINE    13                               2112.73       5181.00       2977.71      (3068.27)        (864.98)  72
      141 TOT:       13                               2112.73       5181.00       2977.71      (3068.27)        (864.98)                1-PTS
      ----------------------------------------------------------------------------------------------------------------------------------
      144 OTHER CIRCULATORY DX, W CC , MEDICAL
      (29.0000-OUTLIER THRESH   7.0000-DRG GMEAN    1.1150-DRG WT     2760.70-HSP PORT     915.67-FED PORT   3661.86-FED RATE)
          ROUTINE    15                               3676.17      10429.00       6074.15      (6752.83)       (2397.98)  76
      144 TOT:       15                               3676.17      10429.00       6074.15      (6752.83)       (2397.98)                1-PTS
      ----------------------------------------------------------------------------------------------------------------------------------
      204 DISORDER OF PANCREAS OTHER THAN MALIGNANCY, MEDICAL
      (30.0000-OUTLIER THRESH   7.5000-DRG GMEAN     .9581-DRG WT     2372.22-HSP PORT     786.64-FED PORT   3146.57-FED RATE)
          ROUTINE    11                               3158.86       4197.00       2388.71      (1038.14)         770.15   75
      204 TOT:       11                               3158.86       4197.00       2388.71      (1038.14)         770.15                 1-PTS
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[illegible]  [illegible]  (ML AND MA CASES ONLY)        PROFIT/LOSS ANALYSIS BY PHYSICIAN AND DRG            (DETAIL REPORT)          PAGE     3
                        HOSPITAL              JAN - MAR 1985     (PROCESSED: 06-11-85 AT 12:20 P.M.)

            DISCH.                                   TOTAL        HOSPITAL       HOSPITAL        CHARGE           COST                REFERENCE
PHYS.  DRG  STATUS    LOS                            REIMBURSE    CHARGE         COST            VARIANCE         VARIANCE    AGE     NUMBER

        ***** MEDICARE NORMAL CASES

        239 PATHOLOGICAL FX AND/OR MALIGNANCY OF MUSCULOSKELETAL SYSTEM AND/OR CONNECTIVE TISSUE, MEDICAL
        (31.0000-OUTLIER THRESH   9.2000-DRG GMEAN   1.0865-DRG WT   2690.13-HSP PORT    892.07-FED PORT   3568.26-FED RATE)

            S.N.F.      16                            3582.20      7392.00        4202.36        (3809.80)        (620.16)   77

        239 TOT:        16                            3582.20      7392.00        4202.36        (3809.80)        (620.16)              1-PTS
------------------------------------------------------------------------------------------------------------------------------------------
        243 BACK DISORDER, MEDICAL
        (30.0000-OUTLIER THRESH   7.5000-DRG GMEAN    .7473-DRG WT   1850.29-HSP PORT    613.57-FED PORT   2454.27-FED RATE)

            ROUTINE     14                            2463.86      7730.00        4237.81        (5266.14)        (1773.95)  75

        243 TOT:        14                            2463.86      7730.00        4237.81        (5266.14)        (1773.95)             1-PTS
------------------------------------------------------------------------------------------------------------------------------------------
        300 ENDOCRINE DISORDER, AGE 0-69 W CC  OR AGE 70+, MEDICAL
        (30.0000-OUTLIER THRESH   7.8000-DRG GMEAN    .9630-DRG WT   2384.35-HSP PORT    790.67-FED PORT   3162.67-FED RATE)

            ROUTINE     24                            3175.02     10369.00        5929.98        (7193.98)        (2754.96)  65

        300 TOT:        24                            3175.02     10369.00        5929.98        (7193.98)        (2754.96)             1-PTS
------------------------------------------------------------------------------------------------------------------------------------------
        301 ENDOCRINE DISORDER, AGE 0-69 WO CC , MEDICAL
        (28.0000-OUTLIER THRESH   6.4000-DRG GMEAN    .8058-DRG WT   1995.13-HSP PORT    661.60-FED PORT   2646.39-FED RATE)

            ROUTINE     11                            2656.73      5295.00        2967.21        (2638.27)        (310.48)   66

        301 TOT:        11                            2656.73      5295.00        2967.21        (2638.27)        (310.48)              1-PTS
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        416 SEPTICEMIA, AGE 18+, MEDICAL
        (37.0000-OUTLIER THRESH   9.2000-DRG GMEAN   1.5343-DRG WT   3798.86-HSP PORT   1259.73-FED PORT   5038.92-FED RATE)

            S.N.F.      15                            5058.59      7101.00        4042.48        (2042.41)        1016.11    84
            ROUTINE     18                            5058.59     10547.00        5393.96        (5488.41)        (335.37)   70

        416 TOT:        33                           10117.18     17648.00        9436.44        (7530.82)         680.74               2-PTS
            AVG:      16.5                            5058.59      8824.00        4718.22        (3765.41)         340.37
------------------------------------------------------------------------------------------------------------------------------------------
        449 POISONING AND/OR TOXIC EFFECTS OF DRUGS, AGE 18-69 W CC  OR AGE 70+, MEDICAL
        (28.0000-OUTLIER THRESH   5.6000-DRG GMEAN    .7255-DRG WT   1796.31-HSP PORT    595.67-FED PORT   2382.67-FED RATE)

            S.N.F.       9                            2391.98      6164.00        3150.14        (3772.02)        (758.16)   89

        449 TOT:         9                            2391.98      6164.00        3150.14        (3772.02)        (758.16)              1-PTS
------------------------------------------------------------------------------------------------------------------------------------------

        ***** MEDICARE NORMAL CASES TOTALS:
                       337                           78876.30    164659.00       91565.17       (85782.70)       (12688.87)             22-PTS

        ***** MEDICARE NORMAL CASES AVERGS:
                      15.3                            3585.29      7484.50        4162.05        (3899.21)        (576.76)
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CS302E    PART-B  (MC AND MA CASES ONLY)    OUTLIER PROFIT/LOSS ANALYSIS BY PHYSICIAN AND DRG
                         HOSPITAL              JAN - MAR 1985     (PROCESSED: 06-11-85 AT 12:20 P.M.)

            DISCH.         DAYS  WAGE-ADJ  OUTLIER      TOTAL        HOSPITAL     HOSPITAL       CHARGE           COST               REFERENCE
PHYS. DRG  STATUS    LOS   OVER  THRESHLD  PAYMENT    REIMBURSE       CHARGE        COST        VARIANCE         VARIANCE   AGE      NUMBER

     ***** MEDICARE OUTLIER CASES

      087 PULMONARY EDEMA AND/OR RESPIRATORY FAILURE, MEDICAL
      (30.0000-OUTLIER THRESH   7.7000-DRG GMEAN   1.5368-DRG WT    3805.06-HSP PORT   1261.78-FED PORT   5047.13-FED RATE)

          S.N.F.     31     1               98.32      5165.16      34486.00     16559.88     (29320.84)     (11394.72)  92

      087 TOT:       31     1               98.32      5165.16      34486.00     16559.88     (29320.84)     (11394.72)             1-PTS
      -----------------------------------------------------------------------------------------------------------------------------

      ***** MEDICARE OUTLIER CASES TOTALS:
                     31     1               98.32      5165.16      34486.00     16559.88     (29320.84)     (11394.72)             1-PTS
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CS302E    PART-C  (MC AND MA CASES ONLY)       PROFIT/LOSS ANALYSIS BY PHYSICIAN AND DRG       (DETAIL REPORT)       PAGE     5
                         HOSPITAL              JAN - MAR 1985     (PROCESSED: 06-11-85 AT 12:20 P.M.)

            DISCH.         DAYS  WAGE-ADJ  OUTLIER      TOTAL        HOSPITAL     HOSPITAL       CHARGE           COST               REFERENCE
PHYS. DRG  STATUS    LOS   OVER  THRESHLD  PAYMENT    REIMBURSE       CHARGE        COST        VARIANCE         VARIANCE   AGE      NUMBER
       CASES TOTALS:
                    368     1               98.32     84041.46     199145.00    108125.05    (115103.54)     (24083.59)            23-PTS
       CASES AVERGS:
                   16.0                                3653.98       8658.48      4701.09      (5004.50)      (1047.11)
```

The Divisions/Departments in the "A" - Revisions column were all briefly reviewed by the Executive Committee. Without exception the changes were quite minor relating to changes in meeting times, occasionally changes in meeting frequency, etc. All of these revisions were reviewed and accepted by the Executive Committee of the Staff.

The Divisions/Departments in "B" - No Revisions column were also accepted by the Executive Committee of the Staff.

NEW BUSINESS

A. Changes & Statistics Reviewed By Those Present

Management of variant utilization by a physician - statistics were presented on 2 areas of activity. The first, dealing with the period 1981-1984, presented data on average length of stay for patients diagnosed as myocardial infarction. During 1981 average length of stay of all patients diagnosed as MI at was 14.83 days. Two physicians, AJ and AG had significantly longer average lengths of stay at 18.4 for AJ and 21.88 for AG. After some discussions and exchanges of letters between the physicians and the Department Head, statistics improved somewhat in 1983 with overall average for all patients now 13.26 days and AJ at 17 days and AG at 19.5 days.

After additional discussions and correspondence the 1984 figures showed significant improvement with the hospital-wide average now 11.1 days, AJ at 12.9 days and AG with too few patients in this category for satisfactory averaging. The changes in statistics were viewed by those present as representing satisfactory improvement although somewhat slow. The Executive Committee believes this matter has been resolved.

Two other utilization statistics were presented relating to the number of termination notices by Utilization Review Committee and retrospective denials by Blue Cross. In 1983 there were, hospital-wide, a total of 81 Termination Notices. Of these, 19 were the patients of one M.D., designated S-4. In 1984 the hospital-wide termination total was 82 and Dr. S-4 was responsible for 21 of these.

In the category of Retrospective Denials by Blue Cross during 1984 there were a hospital-wide total of 208 instances of retrospective denial of payment by Blue Cross. Dr. S-4 was the attending physician in 49 of these cases. At the present time has the privilege of doing its own advance utilization review. If the denial rate goes above 1% Blue Cross will withdraw our advance utilization review privilege which is very undesirable. The problem with Dr. S-4 has continued into 1985. There has been a sharp increase in the number of denials by Blue Cross and we are above the 1% rate presently endangering our advance review privilege.

REVENUE MIX AND DRG PROFIT OR LOSS
BY PHYSICIAN
FOR PATIENTS DISCHARGED DURING THE YEAR ENDED 6/30/

	INPATIENT REVENUE			
NUMBER	PVT PAY	COMMERCIAL	BLUE CROS	MEDICAID
360708				
360600	6,077	50,930	23,748	11,059
800592	25,350	15,066	3,229	5,961
374407	27,710	37,883	12,764	8,306
569100	15,656	110,478	29,909	
8508		848		
200409	10,386	73,106	34,835	
7501	25,141	49,727	18,167	11,268
768502				
444421	11,132		849	
792705	12,654	103,808	8,905	5,199
387908		77,507	9,009	3,899
576204	765	9,607	1,525	3,041
800708	17,169	49,423	877	1,721
179701	498	4,947		2,151
367656	99,357	156,335	39,270	50,690
7013	13,057	9,214	1,362	167
204404	1,576	4,319	2,266	
222224				
378402	13,923	30,114	26,066	4,003
999830	63,655	170,222	28,309	6,038
474703				
30031				
999512				
348104				
555401	4,755	11,663	3,761	1,925
800929				
179809	1,253	990	1,053	
800711				
254118				
674818	27,285	70,857	14,668	20,643
800735				
999849		3,355		
6017	16,050	9,583	4,409	
999822	74,150	193,499	71,516	43,415
444405				
179604				
	15,805	8,625	13,462	475
365106	16,590	27,584	7,309	9,835
800554	26,487	58,641	3,334	349
5010	34,689	148,302	27,836	2,849
569003	1,471	16,074	9,043	
11800	820	9,633	829	780
734918		26,034	10,329	
432105				
297801		1,603		
800600	12,631	38,938	18,010	5,056
388807	4,020	93,232	21,635	8,011
9318	1,264	53,475	1,274	

/85
-JANUARY - JUNE------------------------------------- PROFIT

MEDICARE	TOTAL	DRG REIMB	COST	PROFIT (LOSS) ON MEDICARE
	0			0
423,061	514,875	212,765	295,866	(83,101)
62,351	111,957	39,335	43,472	(4,137)
	86,663			0
399,277	555,320	198,805	288,466	(89,661)
	848			0
133,591	251,918	94,073	100,691	(6,618)
103,845	208,148	107,829	73,741	34,088
	0			0
3,140	15,121	2,890	2,312	578
66,470	197,036	34,875	44,099	(9,224)
137,909	228,324	95,378	99,641	(4,263)
736	15,674	1,947	514	1,433
31,220	100,410	21,239	22,577	(1,338)
7,049	14,645	3,254	4,282	(1,028)
717	346,369	1,411	516	895
2,354	26,154	1,634	1,746	(112)
1,879	10,040	2,377	1,723	654
	0			0
197,872	271,978	168,760	149,659	19,101
81,347	349,571	82,687	58,590	24,097
	0			0
	0			0
	0			0
	0			0
	22,104			0
	0			0
23,491	26,787	15,156	14,556	600
	0			0
	0			0
	133,453			0
2,285	2,285	1,944	1,691	253
4,573	7,928	1,704	3,284	(1,580)
50,307	80,349	24,779	34,875	(10,096)
6,919	389,499	5,630	5,065	565
	0			0
	0			0
675	39,042	1,944	466	1,478
	61,318			0
32,149	120,960	28,449	22,150	6,299
101,129	314,805	74,092	68,353	5,739
45,241	71,829	15,596	28,698	(13,102)
22,062	34,124	22,805	16,414	6,391
1,342	37,705	1,869	918	951
	0			0
	1,603			0
178,352	252,987	66,602	117,920	(51,318)
119,955	246,853	88,746	86,618	2,128
32,042	88,055	21,367	22,172	(805)

REVENUE MIX AND DRG PROFIT OR LOSS
BY PHYSICIAN
FOR PATIENTS DISCHARGED DURING THE YEAR ENDED 6/30

	INPATIENT REVENUE			
NUMBER	PVT PAY	COMMERCIAL	BLUE CROS	MEDICAID
800562	54,257	29,646	14,055	11,181
800742	7,839	39,513	549	
13706	5,838	38,697	5,381	
999857	29,784	22,690	11,188	755
488704	7,693	24,599	5,605	5,114
8028	23,403	132,291	28,423	14,916
800902				
10014				
684406	22,279	76,677	12,129	11,874
999814				
800538				
9016	4,516	71,522	2,733	830
569208	34,712	66,783	19,508	42,675
324108	2,974	30,463	12,509	
510505	42,971	166,549	33,171	11,369
155004	67,126	141,561	38,615	2,314
9024	9,595	20,044	13,460	9,139
258903	2,128	107,575	49,330	
367559	67,481	134,636	15,431	31,061
609706				
270504				
300306	1,676	31,380	11,354	10,483
505218				
20028	10,225	208,719	28,976	2,758
999318				
800546	29,297	62,097	21,309	
366501	8,357	124,192	6,350	15,804
454206	29,254	94,132	26,540	5,768
377309	4,319	105,188	13,959	5,770
800961	22,355	64,417	14,836	17,321
444413	2,968	64,568	53,799	4,775
211206	3,830	15,846	707	
444448				
9032	23,885	89,630	28,344	12,345
TOTALS	1,100,138	3,689,037	917,819	423,093
PERCENTAGE	9.84%	32.99%	8.21%	3.78%

/85

-JANUARY - JUNE-------------------------------------

MEDICARE	TOTAL	DRG REIMB	COST	PROFIT (LOSS) ON MEDICARE
70,401	179,540	53,693	48,231	5,462
28,223	76,124	25,771	20,010	5,761
4,654	54,570	7,206	3,518	3,688
40,891	105,308	16,986	27,662	(10,676)
	43,011			0
117,219	316,252	69,546	82,830	(13,284)
	0			0
	0			0
	122,959			0
	0			0
	0			0
27,232	106,833	17,789	18,843	(1,054)
363,060	526,738	181,719	248,136	(66,417)
24,532	70,478	23,769	18,531	5,238
4,262	258,322	2,405	2,987	(582)
266,329	515,945	183,669	188,879	(5,210)
145,503	197,741	81,647	104,188	(22,541)
7,067	166,100	7,121	5,313	1,808
42,781	291,390	28,309	30,674	(2,365)
	0			0
	0			0
84,691	139,584	47,509	61,921	(14,412)
	0			0
229,547	480,225	100,986	172,280	(71,294)
	0			0
47,157	159,860	44,479	32,793	11,686
209,434	364,137	151,917	144,568	7,349
416,714	572,408	257,854	287,229	(29,375)
11,518	140,754	7,467	8,300	(833)
221,062	339,991	160,814	155,156	5,658
249,402	375,512	159,395	166,374	(6,979)
2,022	22,405	3,055	1,553	1,502
	0			0
164,330	318,534	105,504	111,477	(5,973)
5,051,371	11,181,458	3,178,552	3,552,528	(373,976)
45.18%				

DRG PROFIT OR LOSS
MEDICARE PATIENTS ONLY
FOR PATIENTS DISCHARGED DURING THE YEAR ENDED

DRG	CHARGES	DRG REIMB	COST	PROFIT (LOSS) ON MEDICARE
148	391322	174011	258230	(84,219)
88	373985	164,935	245,265	(80,330)
127	524552	315,201	374,741	(59,540)
89	459671	262,684	313,362	(50,678)
154	215539	89740	136817	(47,077)
320	220080	114432	153206	(38,774)
140	339161	206595	245055	(38,460)
336	230654	130873	166336	(35,463)
146	92769	29286	57399	(28,113)
304	127310	58631	85710	(27,079)
115	70215	23,672	49,762	(26,090)
438	39292	18220	38990	(20,770)
110	154743	77,003	97,201	(20,198)
101	59823	19,737	38,950	(19,213)
116	117242	68,231	86,110	(17,879)
174	167111	99877	117460	(17,583)
221	37867	9400	26064	(16,664)
68	43160	12,250	28,633	(16,383)
468	187359	111045	127072	(16,027)
415	91189	43425	58212	(14,787)
112	78191	40,847	53,566	(12,719)
433	23899	10960	23343	(12,383)
64	22680	3,930	15,948	(12,018)
435	31972	20905	31900	(10,995)
123	126530	76,002	86,968	(10,966)
73	19676	2,471	13,294	(10,823)
15	94732	59,724	70,420	(10,696)
120	46096	23,103	33,248	(10,145)
118	25242	11,567	21,456	(9,889)
199	29590	11076	20568	(9,492)
90	46612	19,729	28,029	(8,300)
460	20363	3659	11793	(8,134)
78	61490	36,603	44,718	(8,115)
312	14857	3908	11546	(7,638)
85	36379	17,872	25,203	(7,331)
436	11115	3833	10874	(7,041)
87	116215	68,368	75,194	(6,826)
356	34357	18316	24804	(6,488)
264	15178	4793	11067	(6,274)
310	68738	42841	48908	(6,067)
337	26489	12865	18764	(5,899)
297	13407	3431	9321	(5,890)
159	21585	8182	13998	(5,816)
434	10409	4505	10296	(5,791)
406	15066	4916	10491	(5,575)
207	57954	34901	39889	(4,988)
211	18984	8457	13321	(4,864)
204	27930	14673	19403	(4,730)
334	30285	16888	21440	(4,552)

6/30/85

	PER DISCHARGE			
NUMBER OF		DRG		(LOSS) ON
PATIENTS	CHARGES	REIMB	COST	MEDICARE
31	12,623.29	5,613.26	8,330.00	(2,716.74)
72	5,194.24	2,290.76	3,406.46	(1,115.69)
139	3,773.76	2,267.63	2,695.98	(428.35)
109	4,217.17	2,409 94	2,874.88	(464.94)
14	15,395.64	6,410.00	9,772.64	(3,362.64)
65	3,385.85	1,760.49	2,357.02	(596.52)
127	2,670.56	1,626.73	1,929.57	(302.83)
60	3,844.23	2,181.22	2,772.27	(591.05)
4	23,192.25	7,321.50	14,349.75	(7,028.25)
14	9,093.57	4,187.93	6,122.14	(1,934.21)
3	23,405.00	7,890.67	16,587.33	(8,696.67)
10	3,929.20	1,822.00	3,899.00	(2,077.00)
11	14,067.55	7,000.27	8,836.45	(1,836.18)
10	5,982 30	1,973.70	3,895.00	(1,921.30)
11	10,658.36	6,202.82	7,828.18	(1,625.36)
50	3,342.22	1,997.54	2,349.20	(351.66)
3	12,622.33	3,133.33	8,688.00	(5,554.67)
9	4,795.56	1,361.11	3,181.44	(1,820.33)
24	7,806.63	4,626.88	5,294.67	(667.79)
6	15,198.17	7,237.50	9,702.00	(2,464.50)
8	9,773.88	5,105.88	6,695.75	(1,589.88)
11	2,172.64	996.36	2,122.09	(1,125.73)
1	22,680.00	3,930.00	15,948.00	(12,018.00)
9	3,552.44	2,322.78	3,544.44	(1,221.67)
30	4,217.67	2,533.40	2,898.93	(365.53)
2	9,838.00	1,235.50	6,647.00	(5,411.50)
42	2,255.52	1,422.00	1,676.67	(254.67)
4	11,524.00	5,775.75	8,312.00	(2,536.25)
3	8,414.00	3,855.67	7,152.00	(3,296.33)
2	14,795.00	5,538.00	10,284.00	(4,746.00)
9	5,179.11	2,192.11	3,114.33	(922.22)
1	20,363.00	3,659.00	11,793.00	(8,134.00)
12	5,124.17	3,050.25	3,726.50	(676.25)
2	7,428.50	1,954.00	5,773.00	(3,819.00)
7	5,197.00	2,553.14	3,600.43	(1,047.29)
2	5,557.50	1,916.50	5,437.00	(3,520.50)
20	5,810.75	3,418.40	3,759.70	(341.30)
10	3,435.70	1,831.60	2,480.40	(648.80)
1	15,178.00	4,793.00	11,067.00	(6,274.00)
28	2,454.93	1,530.04	1,746.71	(216.68)
7	3,784.14	1,837.86	2,680.57	(842.71)
2	6,703.50	1,715.50	4,660.50	(2,945.00)
4	5,396.25	2,045.50	3,499.50	(1,454.00)
2	5,204.50	2,252.50	5,148.00	(2,895.50)
1	15,066.00	4,916.00	10,491.00	(5,575.00)
19	3,050.21	1,836.89	2,099.42	(262.53)
2	9,492.00	4,228.50	6,660.50	(2,432.00)
7	3,990.00	2,096.14	2,771.86	(675.71)
5	6,057.00	3,377.60	4,288.00	(910.40)

DRG PROFIT OR LOSS
MEDICARE PATIENTS ONLY
FOR PATIENTS DISCHARGED DURING THE YEAR ENDED

DRG	CHARGES	DRG REIMB	COST	PROFIT (LOSS) ON MEDICARE
354	32564	19231	23661	(4,430)
213	20143	9413	13811	(4,398)
335	25126	14706	18879	(4,173)
437	5684	1339	5431	(4,092)
208	12381	4748	8763	(4,015)
197	75884	48249	51741	(3,492)
128	33484	22,433	25,881	(3,448)
265	14585	6478	9823	(3,345)
179	11183	4397	7725	(3,328)
344	16977	9699	12607	(2,908)
443	11811	6580	9236	(2,656)
132	25174	15,103	17,581	(2,478)
16	12827	6,583	8,955	(2,372)
97	10554	4,710	6,699	(1,989)
316	22974	14479	16453	(1,974)
144	16389	9758	11656	(1,898)
338	42230	29450	31240	(1,790)
278	9434	5259	6989	(1,730)
339	8237	3958	5585	(1,627)
173	8926	4554	6143	(1,589)
157	25451	17281	18749	(1,468)
75	59944	39,449	40,891	(1,442)
150	10300	5141	6570	(1,429)
49	8319	5,471	6,704	(1,233)
289	14805	8922	10142	(1,220)
454	6026	3561	4768	(1,207)
421	4241	2612	3529	(917)
202	30338	23340	24255	(915)
129	17570	10,065	10,933	(868)
55	7994	4,492	5,294	(802)
22	8060	5,108	5,904	(796)
11	2829	957	1,660	(703)
355	6738	4397	5084	(687)
307	3241	2060	2548	(488)
155	8123	5053	5523	(470)
25	2809	1,381	1,839	(458)
350	6220	3957	4367	(410)
274	9635	6565	6914	(349)
7	6401	4,442	4,789	(347)
241	2995	1959	2298	(339)
99	19788	13,907	14,214	(307)
65	18091	12,612	12,909	(297)
257	22457	16795	17083	(288)
185	6459	4334	4590	(256)
223	3898	2322	2559	(237)
53	5919	3,824	4,052	(228)
342	5240	3662	3827	(165)
225	6132	4204	4360	(156)
153	8001	5456	5592	(136)

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	PER DISCHARGE			
NUMBER OF PATIENTS	CHARGES	DRG REIMB	COST	(LOSS) ON MEDICARE
8	4,070.50	2,403.88	2,957.63	(553.75)
2	10,071.50	4,706.50	6,905.50	(2,199.00)
5	5,025.20	2,941.20	3,775.80	(834.60)
1	5,684.00	1,339.00	5,431.00	(4,092.00)
3	4,127.00	1,582.67	2,921.00	(1,338.33)
15	5,058.93	3,216.60	3,449.40	(232.80)
12	2,790.33	1,869.42	2,156.75	(287.33)
2	7,292.50	3,239.00	4,911.50	(1,672.50)
2	5,591.50	2,198.50	3,862.50	(1,664.00)
4	4,244.25	2,424.75	3,151.75	(727.00)
2	5,905.50	3,290.00	4,618.00	(1,328.00)
8	3,146.75	1,887.88	2,197.63	(309.75)
4	3,206.75	1,645.75	2,238.75	(593.00)
3	3,518.00	1,570.00	2,233.00	(663.00)
5	4,594.80	2,895.80	3,290.60	(394.80)
4	4,097.25	2,439.50	2,914.00	(474.50)
15	2,815.33	1,963.33	2,082.67	(119.33)
3	3,144.67	1,753.00	2,329.67	(576.67)
3	2,745.67	1,319.33	1,861.67	(542.33)
2	4,463.00	2,277.00	3,071.50	(794.50)
10	2,545.10	1,728.10	1,874.90	(146.80)
7	8,563.43	5,635.57	5,841.57	(206.00)
1	10,300.00	5,141.00	6,570.00	(1,429.00)
1	8,319.00	5,471.00	6,704.00	(1,233.00)
3	4,935.00	2,974.00	3,380.67	(406.67)
2	3,013.00	1,780.50	2,384.00	(603.50)
2	2,120.50	1,306.00	1,764.50	(458.50)
9	3,370.89	2,593.33	2,695.00	(101.67)
3	5,856.67	3,355.00	3,644.33	(289.33)
5	1,598.80	898.40	1,058.80	(160.40)
3	2,686.67	1,702.67	1,968.00	(265.33)
1	2,829.00	957.00	1,660.00	(703.00)
2	3,369.00	2,198.50	2,542.00	(343.50)
1	3,241.00	2,060.00	2,548.00	(488.00)
1	8,123.00	5,053.00	5,523.00	(470.00)
1	2,809.00	1,381.00	1,839.00	(458.00)
3	2,073.33	1,319.00	1,455.67	(136.67)
3	3,211.67	2,188.33	2,304.67	(116.33)
2	3,200.50	2,221.00	2,394.50	(173.50)
1	2,995.00	1,959.00	2,298.00	(339.00)
8	2,473.50	1,738.38	1,776.75	(38.38)
12	1,507.58	1,051.00	1,075.75	(24.75)
7	3,208.14	2,399.29	2,440.43	(41.14)
3	2,153.00	1,444.67	1,530.00	(85.33)
1	3,898.00	2,322.00	2,559.00	(237.00)
3	1,973.00	1,274.67	1,350.67	(76.00)
4	1,310.00	915.50	956.75	(41.25)
3	2,044.00	1,401.33	1,453.33	(52.00)
2	4,000.50	2,728.00	2,796.00	(68.00)

DRG PROFIT OR LOSS
MEDICARE PATIENTS ONLY
FOR PATIENTS DISCHARGED DURING THE YEAR ENDED

DRG	CHARGES	DRG REIMB	COST	PROFIT (LOSS) ON MEDICARE
242	4828	3438	3526	(88)
42	9689	6,384	6,463	(79)
40	4762	3,441	3,503	(62)
6	1107	863	900	(37)
66	3592	2,673	2,708	(35)
306	16712	12326	12342	(16)
400	9463	6121	6076	45
219	2977	2332	2253	79
17	7847	5,447	5,352	95
142	1714	1230	1077	153
187	941	864	700	164
84	1894	1,675	1,498	177
311	6439	5080	4870	210
295	4014	3229	3002	227
175	2162	1783	1545	238
450	1453	1287	1023	264
324	1228	1182	916	266
249	8326	6618	6338	280
360	1385	1296	1015	281
177	13283	9635	9314	321
341	19521	12964	12593	371
412	16412	11775	11383	392
263	7069	5356	4962	394
300	8557	6321	5927	394
352	1371	1382	971	411
133	2239	1,862	1,449	413
329	1072	1151	735	416
162	7776	6337	5910	427
32	775	978	548	430
38	734	936	497	439
447	692	1036	589	447
189	7509	5692	5200	492
353	5249	4187	3689	498
165	4343	3497	2955	542
402	2830	2450	1894	556
369	1318	1504	934	570
117	6240	3,943	3,369	574
464	1463	1585	1011	574
47	2554	2,191	1,614	577
357	10722	8309	7725	584
426	9416	8223	7624	599
326	913	1270	656	614
403	7359	5787	5171	616
313	1220	1493	850	643
364	1489	1742	1055	687
56	1618	1,794	1,099	695
308	24158	18081	17374	707
441	1138	1554	824	730
254	2615	2710	1956	754

6/30/85

	PER DISCHARGE			
NUMBER OF PATIENTS	CHARGES	DRG REIMB	COST	(LOSS) ON MEDICARE
1	4,828.00	3,438.00	3,526.00	(88.00)
5	1,937.80	1,276.80	1,292.60	(15.80)
4	1,190.50	860.25	875.75	(15.50)
1	1,107.00	863.00	900.00	(37.00)
3	1,197.33	891.00	902.67	(11.67)
5	3,342.40	2,465.20	2,468.40	(3.20)
1	9,463.00	6,121.00	6,076.00	45.00
1	2,977.00	2,332.00	2,253.00	79.00
3	2,615.67	1,815.67	1,784.00	31.67
1	1,714.00	1,230.00	1,077.00	153.00
1	941.00	864.00	700.00	164.00
1	1,894.00	1,675.00	1,498.00	177.00
4	1,609.75	1,270.00	1,217.50	52.50
2	2,007.00	1,614.50	1,501.00	113.50
1	2,162.00	1,783.00	1,545.00	238.00
1	1,453.00	1,287.00	1,023.00	264.00
1	1,228.00	1,182.00	916.00	266.00
3	2,775.33	2,206.00	2,112.67	93.33
1	1,385.00	1,296.00	1,015.00	281.00
6	2,213.83	1,605.83	1,552.33	53.50
6	3,253.50	2,160.67	2,098.83	61.83
16	1,025.75	735.94	711.44	24.50
1	7,069.00	5,356.00	4,962.00	394.00
3	2,852.33	2,107.00	1,975.67	131.33
1	1,371.00	1,382.00	971.00	411.00
1	2,239.00	1,862.00	1,449.00	413.00
1	1,072.00	1,151.00	735.00	416.00
5	1,555.20	1,267.40	1,182.00	85.40
1	775.00	978.00	548.00	430.00
1	734.00	936.00	497.00	439.00
1	692.00	1,036.00	589.00	447.00
4	1,877.25	1,423.00	1,300.00	123.00
1	5,249.00	4,187.00	3,689.00	498.00
1	4,343.00	3,497.00	2,955.00	542.00
1	2,830.00	2,450.00	1,894.00	556.00
1	1,318.00	1,504.00	934.00	570.00
1	6,240.00	3,943.00	3,369.00	574.00
1	1,463.00	1,585.00	1,011.00	574.00
2	1,277.00	1,095.50	807.00	288.50
2	5,361.00	4,154.50	3,862.50	292.00
4	2,354.00	2,055.75	1,906.00	149.75
1	913.00	1,270.00	656.00	614.00
3	2,453.00	1,929.00	1,723.67	205.33
1	1,220.00	1,493.00	850.00	643.00
2	744.50	871.00	527.50	343.50
2	809.00	897.00	549.50	347.50
8	3,019.75	2,260.13	2,171.75	88.38
1	1,138.00	1,554.00	824.00	730.00
2	1,307.50	1,355.00	978.00	377.00

DRG PROFIT OR LOSS
MEDICARE PATIENTS ONLY
FOR PATIENTS DISCHARGED DURING THE YEAR ENDED

DRG	CHARGES	DRG REIMB	COST	PROFIT (LOSS) ON MEDICARE
305	9140	7373	6603	770
258	8248	6964	6182	782
328	999	1409	626	783
251	672	1289	494	795
114	10931	9,122	8,314	808
45	5154	4,511	3,652	859
119	1776	2,297	1,381	916
463	2766	3332	2409	923
284	359	1293	349	944
167	2085	2342	1397	945
363	2791	2819	1873	946
247	6281	5678	4702	976
234	2386	2691	1706	985
149	5097	4787	3746	1,041
46	300	1,291	232	1,059
178	2157	2654	1556	1,098
332	827	1681	583	1,098
273	937	1794	670	1,124
31	7568	6,550	5,425	1,125
418	1361	2158	1012	1,146
135	1608	2,144	986	1,158
419	12244	9336	8150	1,186
169	4174	3890	2689	1,201
18	2751	3,421	2,177	1,244
366	3151	3656	2402	1,254
290	3249	3698	2420	1,278
248	3786	3983	2702	1,281
102	735	1,954	655	1,299
229	3533	3893	2577	1,316
398	5381	5777	4444	1,333
272	3152	3725	2339	1,386
259	1074	2191	741	1,450
270	2762	3518	2055	1,463
409	2871	3519	2052	1,467
401	1814	2687	1200	1,487
262	5039	4998	3509	1,489
158	3409	4159	2665	1,494
277	22562	17724	16137	1,587
126	5766	5,769	4,152	1,617
283	1363	2769	1133	1,636
452	5410	5512	3801	1,711
285	6410	6205	4479	1,726
20	5585	6,064	4,310	1,754
411	1839	3124	1338	1,786
233	2730	3840	2044	1,796
28	744	2,317	516	1,801
266	5871	6153	4340	1,813
191	10922	9048	7230	1,818
145	489	2169	348	1,821

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6/30/85

	PER DISCHARGE			
NUMBER OF PATIENTS	CHARGES	DRG REIMB	COST	(LOSS) ON MEDICARE
2	4,570.00	3,686.50	3,301.50	385.00
3	2,749.33	2,321.33	2,060.67	260.67
1	999.00	1,409.00	626.00	783.00
1	672.00	1,289.00	494.00	795.00
2	5,465.50	4,561.00	4,157.00	404.00
4	1,288.50	1,127.75	913.00	214.75
1	1,776.00	2,297.00	1,381.00	916.00
2	1,383.00	1,666.00	1,204.50	461.50
1	359.00	1,293.00	349.00	944.00
1	2,085.00	2,342.00	1,397.00	945.00
2	1,395.50	1,409.50	936.50	473.00
4	1,570.25	1,419.50	1,175.50	244.00
1	2,386.00	2,691.00	1,706.00	985.00
1	5,097.00	4,787.00	3,746.00	1,041.00
1	300.00	1,291.00	232.00	1,059.00
2	1,078.50	1,327.00	778.00	549.00
1	827.00	1,681.00	583.00	1,098.00
1	937.00	1,794.00	670.00	1,124.00
5	1,513.60	1,310.00	1,085.00	225.00
1	1,361.00	2,158.00	1,012.00	1,146.00
1	1,608.00	2,144.00	986.00	1,158.00
5	2,448.80	1,867.20	1,630.00	237.20
2	2,087.00	1,945.00	1,344.50	600.50
2	1,375.50	1,710.50	1,088.50	622.00
2	1,575.50	1,828.00	1,201.00	627.00
2	1,624.50	1,849.00	1,210.00	639.00
3	1,262.00	1,327.67	900.67	427.00
1	735.00	1,954.00	655.00	1,299.00
3	1,177.67	1,297.67	859.00	438.67
3	1,793.67	1,925.67	1,481.33	444.33
2	1,576.00	1,862.50	1,169.50	693.00
1	1,074.00	2,191.00	741.00	1,450.00
2	1,381.00	1,759.00	1,027.50	731.50
2	1,435.50	1,759.50	1,026.00	733.50
1	1,814.00	2,687.00	1,200.00	1,487.00
5	1,007.80	999.60	701.80	297.80
3	1,136.33	1,386.33	888.33	498.00
10	2,256.20	1,772.40	1,613.70	158.70
1	5,766.00	5,769.00	4,152.00	1,617.00
2	681.50	1,384.50	566.50	818.00
3	1,803.33	1,837.33	1,267.00	570.33
1	6,410.00	6,205.00	4,479.00	1,726.00
3	1,861.67	2,021.33	1,436.67	584.67
2	919.50	1,562.00	669.00	893.00
1	2,730.00	3,840.00	2,044.00	1,796.00
1	744.00	2,317.00	516.00	1,801.00
3	1,957.00	2,051.00	1,446.67	604.33
1	10,922.00	9,048.00	7,230.00	1,818.00
1	489.00	2,169.00	348.00	1,821.00

DRG PROFIT OR LOSS
MEDICARE PATIENTS ONLY
FOR PATIENTS DISCHARGED DURING THE YEAR ENDED

DRG	CHARGES	DRG REIMB	COST	PROFIT (LOSS) ON MEDICARE
349	3758	4545	2666	1,879
80	2974	3,777	1,876	1,901
23	660	2,505	505	2,000
164	2384	3966	1902	2,064
63	7288	7,199	5,102	2,097
449	19981	15860	13716	2,144
92	8575	7,887	5,717	2,170
24	29379	25,378	23,207	2,171
27	325	2,461	240	2,221
161	25054	21410	19182	2,228
218	9366	9250	6977	2,273
152	9766	9634	7332	2,302
423	30495	23571	21205	2,366
303	29061	21973	19483	2,490
256	6715	7540	5034	2,506
238	973	3352	788	2,564
131	10094	10,270	7,627	2,643
397	1951	4267	1522	2,745
39	131481	82,355	79,513	2,842
170	19955	17416	14337	3,079
425	5297	7368	4068	3,300
358	4934	7073	3767	3,306
407	1706	4626	1282	3,344
183	25132	20786	17320	3,466
444	5161	7643	4134	3,509
244	15990	15177	11662	3,515
321	6953	8834	5294	3,540
181	7024	8486	4942	3,544
429	8233	10301	6635	3,666
430	8668	11222	7490	3,732
318	2688	5934	2180	3,754
134	10204	12,207	8,368	3,839
217	1465	4942	1101	3,841
188	31827	25782	21933	3,849
269	6645	8610	4746	3,864
180	23695	21280	17322	3,958
10	10782	11,323	7,344	3,979
231	3038	6179	2176	4,003
83	5459	8491	4431	4,060
172	34393	29197	25074	4,123
34	5342	7,961	3,590	4,371
122	121972	98,704	94,238	4,466
192	17831	16956	12464	4,492
1	3469	7,263	2,675	4,588
198	12324	13793	9159	4,634
82	61159	47,411	42,712	4,699
331	38781	31137	26309	4,828
325	16498	17248	12245	5,003
168	11526	13077	7990	5,087

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NUMBER OF PATIENTS	PER DISCHARGE CHARGES	DRG REIMB	COST	(LOSS) ON MEDICARE
3	1,252.67	1,515.00	888.67	626.33
1	2,974.00	3,777.00	1,876.00	1,901.00
1	660.00	2,505.00	505.00	2,000.00
1	2,384.00	3,966.00	1,902.00	2,064.00
3	2,429.33	2,399.67	1,700.67	699.00
10	1,998.10	1,586.00	1,371.60	214.40
5	1,715.00	1,577.40	1,143.40	434.00
16	1,836.19	1,586.13	1,450.44	135.69
1	325.00	2,461.00	240.00	2,221.00
14	1,789.57	1,529.29	1,370.14	159.14
3	3,122.00	3,083.33	2,325.67	757.67
3	3,255.33	3,211.33	2,444.00	767.33
9	3,388.33	2,619.00	2,356.11	262.89
4	7,265.25	5,493.25	4,870.75	622.50
4	1,678.75	1,885.00	1,258.50	626.50
1	973.00	3,352.00	788.00	2,564.00
5	2,018.80	2,054.00	1,525.40	528.60
2	975.50	2,133.50	761.00	1,372.50
76	1,730.01	1,083.62	1,046.22	37.39
3	6,651.67	5,805.33	4,779.00	1,026.33
5	1,059.40	1,473.60	813.60	660.00
3	1,644.67	2,357.67	1,255.67	1,102.00
1	1,706.00	4,626.00	1,282.00	3,344.00
17	1,478.35	1,222.71	1,018.82	203.88
4	1,290.25	1,910.75	1,033.50	877.25
9	1,776.67	1,686.33	1,295.78	390.56
6	1,158.83	1,472.33	882.33	590.00
5	1,404.80	1,697.20	988.40	708.80
5	1,646.60	2,060.20	1,327.00	733.20
5	1,733.60	2,244.40	1,498.00	746.40
3	896.00	1,978.00	726.67	1,251.33
8	1,275.50	1,525.88	1,046.00	479.88
1	1,465.00	4,942.00	1,101.00	3,841.00
16	1,989.19	1,611.38	1,370.81	240.56
4	1,661.25	2,152.50	1,186.50	966.00
12	1,974.58	1,773.33	1,443.50	329.83
4	2,695.50	2,830.75	1,836.00	994.75
3	1,012.67	2,059.67	725.33	1,334.33
4	1,364.75	2,122.75	1,107.75	1,015.00
11	3,126.64	2,654.27	2,279.45	374.82
4	1,335.50	1,990.25	897.50	1,092.75
34	3,587.41	2,903.06	2,771.71	131.35
2	8,915.50	8,478.00	6,232.00	2,246.00
1	3,469.00	7,263.00	2,675.00	4,588.00
5	2,464.80	2,758.60	1,831.80	926.80
20	3,057.95	2,370.55	2,135.60	234.95
16	2,423.81	1,946.06	1,644.31	301.75
11	1,499.82	1,568.00	1,113.18	454.82
7	1,646.57	1,868.14	1,141.43	726.71

DRG PROFIT OR LOSS
MEDICARE PATIENTS ONLY
FOR PATIENTS DISCHARGED DURING THE YEAR ENDED

DRG	CHARGES	DRG REIMB	COST	PROFIT (LOSS) ON MEDICARE
442	57116	43492	38389	5,103
0	21342	21,342	16,162	5,180
141	36905	32228	26984	5,244
467	7174	10603	5331	5,272
176	18965	18845	13283	5,562
235	10293	15230	9444	5,786
280	10950	14756	8953	5,803
138	153941	114,664	108,816	5,848
94	13343	15,555	9,472	6,083
121	204324	159,152	153,030	6,122
96	100190	76,146	69,947	6,199
348	28527	26853	20305	6,548
323	21666	21600	14964	6,636
193	12998	15901	9262	6,639
205	14288	18736	11552	7,184
250	7310	12847	5658	7,189
130	26302	27,139	19,937	7,202
12	9558	14,447	7,155	7,292
5	20912	21,770	14,335	7,435
239	22905	25810	18222	7,588
346	12092	16272	8595	7,677
139	15466	19761	11909	7,852
143	58219	48672	40802	7,870
203	15008	18929	11033	7,896
416	19728	21587	13501	8,086
294	55050	50762	42078	8,684
271	10033	17906	8365	9,541
253	16179	24233	13674	10,559
240	18775	25204	14399	10,805
236	25246	29974	18406	11,568
195	82394	70377	58078	12,299
182	177129	143566	131093	12,473
395	47905	49188	34038	15,150
113	8881	23,210	7,123	16,087
296	112460	97139	81010	16,129
243	58170	66676	44398	22,278
79	71564	73,948	48,748	25,200
210	186500	157898	129834	28,064
14	335144	276,919	239,609	37,310
209	332247	274308	220696	53,612
	9,623,733	6,482,593	6,765,811	(283,218)

6/30/85

	PER DISCHARGE			
NUMBER OF PATIENTS	CHARGES	DRG REIMB	COST	(LOSS) ON MEDICARE
10	5,711.60	4,349.20	3,838.90	510.30
7	3,048.86	3,048.86	2,308.86	740.00
23	1,604.57	1,401.22	1,173.22	228.00
5	1,434.80	2,120.60	1,066.20	1,054.40
7	2,709.29	2,692.14	1,897.57	794.57
4	2,573.25	3,807.50	2,361.00	1,446.50
11	995.45	1,341.45	813.91	527.55
57	2,700.72	2,011.65	1,909.05	102.60
5	2,668.60	3,111.00	1,894.40	1,216.60
42	4,864.86	3,789.33	3,643.57	145.76
44	2,277.05	1,730.59	1,589.70	140.89
14	2,037.64	1,918.07	1,450.36	467.71
14	1,547.57	1,542.86	1,068.86	474.00
3	4,332.67	5,300.33	3,087.33	2,213.00
8	1,786.00	2,342.00	1,444.00	898.00
8	913.75	1,605.88	707.25	898.63
13	2,023.23	2,087.62	1,533.62	554.00
6	1,593.00	2,407.83	1,192.50	1,215.33
6	3,485.33	3,628.33	2,389.17	1,239.17
12	1,908.75	2,150.83	1,518.50	632.33
8	1,511.50	2,034.00	1,074.38	959.63
11	1,406.00	1,796.45	1,082.64	713.82
33	1,764.21	1,474.91	1,236.42	238.48
8	1,876.00	2,366.13	1,379.13	987.00
7	2,818.29	3,083.86	1,928.71	1,155.14
29	1,898.28	1,750.41	1,450.97	299.45
6	1,672.17	2,984.33	1,394.17	1,590.17
15	1,078.60	1,615.53	911.60	703.93
12	1,564.58	2,100.33	1,199.92	900.42
10	2,524.60	2,997.40	1,840.60	1,156.80
15	5,492.93	4,691.80	3,871.87	819.93
107	1,655.41	1,341.74	1,225.17	116.57
29	1,651.90	1,696.14	1,173.72	522.41
4	2,220.25	5,802.50	1,780.75	4,021.75
50	2,249.20	1,942.78	1,620.20	322.58
41	1,418.78	1,626.24	1,082.88	543.37
19	3,766.53	3,892.00	2,565.68	1,326.32
35	5,328.57	4,511.37	3,709.54	801.83
98	3,419.84	2,825.70	2,444.99	380.71
55	6,040.85	4,987.42	4,012.65	974.76
2,741	1,033,037	719,377	732,486	(13,109)

PHYSICIAN:

DRG	TOT # CASES	TOT# OUTL	%HOSP CASES	AVG LOS	REG ALOS	TOTAL PT DYS	OUTL DAYS	TOTAL REIMB	TOTAL CHARGES	TOTAL COST	TOTAL VARIANCE	AVERAGE TOT ANC	AVERAGE ANCILLARY CHARGES LAB	I/R	RX	SURG
416	2	1	0.07	26	5.0	51	15	13,678	36,776	20,985	(7307)	11,434	1,206	142	2,112	0
127	4	0	0.14	10	7.0	41	0	16,376	31,787	17,947	(1571)	4,037	1,220	269	451	0
320	1	1	0.03	40	6.0	40	11	3,872	26,051	16,277	(12405)	10,352	2,239	673	2,374	0

PHYSICIAN PROFILE
Hospital,
Run On: 04/04/85 At: 14:22

Financial Classes:A,M,U,Y

Page No: 25

For Discharges Between: 07/01/84 And 02/28/85

Ranked By Total Charges

121	2	0	0.07	16	11.0	31	0	14,677	22,235	12,387	2290	6,385	893	134	528	0
122	3	1	0.10	5	9.0	15	0	14,031	21,938	13,740	291	4,157	872	48	747	0
89	3	0	0.10	7	8.0	22	0	13,018	16,228	10,204	2814	3,415	700	331	776	0
14	2	0	0.07	11	9.0	22	0	10,641	14,827	10,125	516	3,916	661	24	521	0
99	2	0	0.07	8	5.0	16	0	6,321	14,023	7,660	(1339)	4,448	838	119	804	0
125	2	0	0.07	6	2.0	11	0	12,951	10,553	6,522	6429	2,706	392	47	115	0
294	4	0	0.14	5	6.0	18	0	12,730	7,825	6,145	6585	740	365	72	127	0
203	2	0	0.07	7	7.0	13	0	8,604	6,569	4,614	3990	1,528	432	63	169	0
236	1	0	0.03	17	10.0	17	0	5,450	5,508	4,877	573	896	163	239	152	0
277	1	0	0.03	8	7.0	8	0	3,486	5,499	3,440	46	3,337	434	47	2,072	0
15	2	0	0.07	6	3.0	12	0	5,250	5,423	3,973	1277	1,016	213	24	38	0
140	1	0	0.03	4	4.0	4	0	2,972	4,315	1,819	1153	1,028	533	47	171	0
182	1	0	0.03	6	5.0	6	0	2,433	3,614	2,546	(113)	1,993	223	376	606	0
141	1	0	0.03	7	4.0	7	0	2,547	3,059	2,533	14	1,166	329	128	13	0
97	1	0	0.03	3	5.0	3	0	2,854	3,054	1,622	1232	2,244	664	48	338	0
403	1	0	0.03	6	6.0	6	0	4,608	3,003	2,223	2385	1,381	899	48	111	0
296	1	0	0.03	5	5.0	5	0	3,532	2,985	1,980	1552	1,547	730	48	43	0
79	1	0	0.03	5	11.0	5	0	7,073	2,879	1,960	5113	1,525	416	96	568	0
138	1	0	0.03	5	5.0	5	0	3,660	2,775	2,100	1560	1,425	310	48	37	0
24	1	0	0.03	4	4.0	4	0	2,866	2,020	1,449	1417	948	342	77	47	0
318	1	0	0.03	3	4.0	3	0	3,596	1,810	1,391	2205	1,000	198	175	38	456
297	1	0	0.03	3	4.0	3	0	3,117	1,809	1,182	1935	997	325	48	100	0
243	1	0	0.03	4	6.0	4	0	2,970	1,676	1,440	1530	596	159	309	21	0
134	1	0	0.03	2	4.0	2	0	2,773	1,365	860	1913	825	136	0	170	0
83	1	0	0.03	3	5.0	3	0	3,858	1,310	1,054	2804	499	198	101	74	0
TOTALS	45	3				377	26	189,944	261,644	163,055	26809					

```
PERIOD [redacted]
R.DRG300.1   SEQ: PHY  DRG                          DRG ANALYSIS - DETAIL
                                                                   HOSPITAL                                                  DATE 08/19/85
                                                                                                                             PAGE  9
DRG  MR #  DISCHARGE PATIENT NAME            PHY FC-P SC CTY  ZIP   PRIM    PRIM    LOS   ALLOW    TOTAL    CHARGE   TOTAL     COST
CDE           DATE                           NBR              CDE   DIAG    SURG           $$     CHARGES     VAR     COST      VAR

140 023455 07/30/85                          10287 02-1 01   0 93307 411.1              1    2680     1191     1489     1083     1596
    **DRG TOTAL ANGINA PECTORIS                                # CASES      1                 2680              1489              1596
                                                                                        1               1191              1083
                                                               AVERAGE                1.0    2680     1191     1489     1083     1596
214 022528 07/15/85                          10287 03-1 01   0 93206 724.4  80.5        14    6543     7304     -761     6004      538
    **DRG TOTAL BACK, NECK OP +/G                              # CASES      1                 6543              -761               538
                                                                                       14               7304              6004
                                                               AVERAGE               14.0    6543     7304     -761     6004      538
395 022283 07/09/85                          10287 01-1 01   0 93308 285.9               4    2783     1849      934     1532     1250
    **DRG TOTAL RED BLOOD CELL DX AG                           # CASES      1                 2783               934              1250
                                                                                        4               1849              1532
                                                               AVERAGE                4.0    2783     1849      934     1532     1250
416 022283 07/25/85                          10287 01-1 01   0 93308 038 40             15    5505    11314    -5809     8930    -3425
    **DRG TOTAL SEPTICEMIA AG                                  # CASES      1                 5505             -5809             -3425
                                                                                       15              11314              8930
                                                               AVERAGE               15.0    5505    11314    -5809     8930    -3425

    ***PHY TOTAL                                               # CASES      4                17511             -4147               -40
                                                                                       34              21658             17551
                                                               AVERAGE                8.5    4377     5414    -1036     4387      -10
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INDEX V

ADDITIONAL WRITTEN TESTIMONY RECEIVED FOR THE RECORD

September 24, 1985 letter from John Feather, Ph.D., Associate Director, Western New York Geriatric Education Center, State University of New York, to Senator John Heniz re: effect of Prospective Payment (PPS) on hospital discharge planning, staffing and processing.

September 26, 1986 written statement by Barbara Jones, Davidson County Health Department, submitted for the Record re: impact of PPS on Medicare beneficiaries in the Davidson County home health care program.

October 16, 1985 letter from Bernice Lazar, RN, Visiting Nurse Services, South King County Office, to Senator John Heniz re: negative impact of Diagnosis Related Groups (DRG's) on the quality of health care of terminally ill Medicare and Medicaid beneficiaries.

October 24, 1985 written statement by Betsy Vourlekis, National Association of Social Workers, submitted for the Record re: the impact of PPS and DRG's on hospital discharge planning.

October 31, 1985 letter from John Massard, Administrator, Elmhurst Extended Care Center Inc., to Senator John Heinz re: the increase in benefit denials of claims made by Medicare beneficiaries.

November 13, 1986 letter from Sharon Ahern, California PRO, transmitting written statement by Eva Skinner, Board of Directors, California PRO, submitted for the Record re: the role of Peer Review Organizations (PRO's) in assuring quality health care for Medicare beneficiaries (attachment).

November 13, 1985 written statement by Lois K. Evans, RN, DNSC, Assistant Professor of Nursing, University of Pennsylvania re: the impact of DRG's on the quality of long-term, nursing home care.

November 14, 1985 written statement by Charles B. Inlander, Executive Director, People's Medical Society, to be submitted for the Record re: patient "dumping" and the impact of DRG's and PPS on the health care system.

December 17, 1985 letter from Mario V. Mirabelli, Shea & Gould transmitting written statement of Glasrock Home Health Care, Inc. to Senator John Heinz submitted for the Record re: impact of PPS on Home Health and Durable Medical Equipment providers.

January 31, 1986 letter from Jay B. Culter, Special Counsel and Director, Division of Government Relations, American Psychiatric Association, to Senator John Heinz re: evaluation of psychiatric DRG's and it's potential impact on the quality of care of mentally ill Medicare beneficiaries.

UNIVERSITY AT BUFFALO
STATE UNIVERSITY OF NEW YORK

Western New York Geriatric Education Center
Beck Hall
3435 Main Street
Buffalo, New York 14214
[illegible]

September 24, 1985

Senator John Heinz, Chairman
United States Senate
Special Committee on Aging
G33 Dirksen Senate Office Building
Washington, D.C.

Dear Senator Heinz:

Thank you for giving me the opportunity to provide information on the effects of prospective payment on hospital discharge planning for long term care. This is an especially important topic for the elderly, since shorter acute care hospital stays give the discharge planner less time to complete the often complex arrangements needed by the elderly as they transfer to other levels of care.

The statistical information presented in this letter comes from a national study of hospital discharge planners conducted by Dr. Linda Nichols, Veterans Administration Medical Center, Memphis, and myself over the past three years. While the study is limited by the number of hospitals represented and other methodological issues, it is the only national study based on a random sample of all U.S. hospitals that is directly concerned with problems of discharge planning for continuity of care. The "discussion" sections are based on observations and interaction with discharge planners across the country, and contain our interpretative comments that extend beyond the scope of the data.

Study Design. The study focused on the effect of prospective payment on hospital discharge planning by interviewing discharge planners both before and after prospective payment was implemented. Two hundred accredited U.S. hospitals were selected at random, and questionnaires were sent to all discharge planners within each hospital in December, 1982. In June-August, 1984, respondents from the first phase of the study were recontacted. Some questions were repeated exactly as in the first interview, while a number of other questions were added specifically addressing changes due to prospective payment. Because some states were not using prospective payment for Medicare reimbursement, some discharge planners were eliminated from the sample, leaving a total of 121 valid respondents who answered both questionnaires.

To make this material easier to utilize, it has been arranged into separate sections for each topic. In each case, the general conclusion based on the data has been stated first, followed by the evidence supporting that conclusion, and a discussion.

[illegible] by the Bureau of Health Professions
[illegible] of Health & Human Services

Affiliated with the Network in Aging
of Western New York, Inc.

GREATER EMPHASIS ON DISCHARGE PLANNING

Most discharge planners (71%) report that discharge planning receives more emphasis since the implementation of prospective payment. This emphasis has led to the greater use of interdisciplinary teams (39%) and a slight increase (11%) in the use of special units whose sole responsibility is discharge planning. Discharge planning still remains the responsibility of nursing and social work, with only 5% of hospitals transferring discharge planning to administration or the fiscal office of the hospital.

Discussion: Prospective payment has increased the visibility and importance of discharge planning in the hospital, since the new system links reimbursement with timely patient discharge. A hospital that cannot discharge a patient as soon as medically possible because of ineffective discharge planning will suffer greatly under the new system. This emphasis has led to a greater reliance on interdisciplinary teams (usually made up of nurses, social workers, physicians, and physical therapists) who can develop an integrated discharge plan and who can anticipate most potential problems. Some critics feared that pressure for early discharge would lead to discharge planning being reorganized under the fiscal office of the hospital, and that financial considerations would take precedence over medical considerations in the decision to discharge. Currently, this does not seem to be the case, although comments from discharge planners indicate that many hospitals are at least considering such an arrangement.

INCREASED WORKLOAD

Over half (56%) of the discharge planners report an increase in workload since prospective payment, with the average increase being 25%. However, this increase in work has not led to an increase in staff in most (79%) cases.

Discussion: As elderly patients are released from the hospital more quickly than in the past, many have more complex continuing care needs, causing an increase in the work of discharge planners. In addition, shorter average length of stay means more patient turnover, also increasing discharge planning work.

Hospitals are generally not increasing staff to meet this increased work load. This may be due to the time lag before discharge planning is recognized as a critical part of overall hospital care, and that hospitals will eventually "catch up" with the new need. Some respondents report that although the discharge planning staff has not increased, it has not been cut as have other hospital departments. It may be, however, that since discharge planning is not a direct revenue producing activity, some hospitals are trying to do more with the same staff. If this results in poorer discharge planning, the elderly are likely to suffer more than others, since they often have the most complex problems and are most likely to need some type of continuing care (e.g., nursing home, home health care).

DECREASED PATIENT FOLLOW-UP

Discharge planners measure the post-hospital adjustment of patients less frequently since prospective payment, falling from 32% of patients before to 15% presently.

Discussion: Due to increased workload, discharge planners have less time to follow-up on patients after they leave the hospital. This is especially true for systematic follow-up using written assessment forms. Discharge planners are hospital employees, and, although they attempt to bridge the gap between acute care and long term care, they must respond to the hospital's needs first. With prospective payment, these needs include timely discharge, but do not necessarily include the tracking of patients afterwards.

Since the Peer Review Organizations will now be reviewing all patients who return to the hospital within fourteen days, many hospitals are trying to become more systematic in identifying problems in discharge arrangements that might lead to the patient being readmitted. The question remains, however, as to whether or not hospitals, with discharge planning resources already severly strained, will be able to provide needed follow-up.

The elderly especially need systematic follow-up after hospitalization. Transfer from one level of care to another can lead to confusion and anxiety in anyone, and can actually be hazardous to physical health as well. If the elderly person does not have an advocate who is sophisticated in dealing with the disjointed continuing health care scene, the patient's problems may not be brought to attention of medical and other personnel in the hospital who developed the discharge plan. Because their health and social needs are more complex, the elderly are more likely to have such problems, and therefore are especially vulnerable to "falling between the cracks" of the continuing health care system.

ACCESS TO CARE FOR THE ELDERLY

Most discharge planners (62%) report that prospective payment has not changed the access to care for the elderly in their hospital. Twenty-nine percent report that the new system has worsened access to care, while only 9% feel the system has improved access to care for the elderly.

Discussion: The critical issue involving prospective payment and the elderly is whether or not the elderly on Medicare will be systematically discriminated against by hospitals in favor of younger patients with less complex medical problems or elderly private pay patients. Most discharge planners do not see access to care being denied the elderly in their hospitals, although a substantial minority feel access to care has worsened. While this finding is not as bad as expected, a cautionary note must be added.

Prospective payment, as expected, has caused a reduction in census at most hospitals as the average length of stay decreases. In many hospitals, this decrease has been quite precipitous. Because most hospitals now operate below capacity, they are anxious admit all available patients, and since the elderly are disproportionately high users of hospital services, some hospitals are actively soliciting their business. As long as average census remains low, access to care should not be a special problem for the elderly on Medicare.

However, some acute care hospitals will not survive the transition to prospective payment. As hospitals disappear, the current surplus of acute care beds will decrease. Once the remaining hospitals have a high daily census again, they may begin looking at the types of patients that "make money" for the hospital. The diagnosis related groups (DRGs) are based on an acute care model that may not adequately take into account the underlying chronic diseases and slower recovery rate of the elderly. If hospitals can fill their beds with patients who have less complex problems and who can be discharged faster, they may do so.

The prospective payment system may thus give hospitals an incentive to discriminate against the elderly. Many hospitals are also developing the mechanism that can be used to screen away elderly patients who are likely to lose money for the hospital under the DRG system. Thirty-nine percent of our discharge planners report that their hospital has begun pre-admission screening for discharge problems since prospective payment. Screening identifies those patients who will need continuing care placement after hospitalization. Arrangements can be made while the patient is still in the hospital, so that the patient is not forced to remain in the hospital longer than medically necessary because of the lack of a long term care bed. This most instances, pre-admission screening of a great benefit to the elderly, since difficult problems can be addressed over the course of a longer period of time. However, this mechanism can also be used to identify patients who are going to be hard to place (e.g., patients in need of a Medicaid skilled nursing bed). It is a small step from systematically identifying these patients to systematically restricting access to care for them. While this is not currently a problem, policy makers should watch the situation carefully.

HOSPITAL VERTICAL INTEGRATION INCREASING

Many hospital have increased the range of services provided to patients, including long term care services traditionally offered elsewhere. Twenty-one percent of discharge planners report that, since the implementation of prospective payment, their hospital has begun hospital-based home health care. Other options include opening a day hospital (21%), a health related facility (17%), a skilled nursing facility (9%), and selling durable medical equipment (16%).

Discussion: "Vertical integration," or providing a full range of services, in hospitals has both positive and negative aspects for the elderly. The elderly suffer under the present disjointed continuum of health care. They need, more than any other group, an integrated system of services, so that changes in their health status can be quickly reflected in changes in the health care they receive. Presently, the transition between levels of care (e.g., hospital, home health care, nursing home) is often difficult. If one company provides all levels of care, the transfer of patients from one level to another will be easier. Patients are less likely to be "lost in the shuffle" if the same health care team is managing their care continuously. Under this approach, the company also has an incentive to take patients with more complex health problems, as often characterizes the elderly. A company with a full range of services may be willing to take a patient whose acute hospital stay will lose money under the DRG system, but who will be placed in the company's long term care facility.

The continuity of care provided by vertical integration is a plus for the elderly, but this system is also likely to reduce competition in the provision of health care. If one company can offer everything needed in long term care, why would a patient chose another company that specializes in home health care? The currently fierce competition in home health care causes many companies to offer specialized services for the elderly that they may not continue if they were assured a steady supply of patients from the hospital. Since vertical integration is well established and growing in the health care field, the effects on competition should be carefully followed.

RURAL HOSPITALS

Discussion: Our study contains no specific information on rural hospitals. However, we have discussed this issue with a number of discharge planners at rural hospitals across the nation, and our impressions of the special problems of these hospitals may be useful.

The problems of rural hospitals need to be divided into two main components: the effects of the rural setting, and the effects of size. Not all rural hospitals are small, and the larger hospitals have adapted to the system differently than the smaller ones. Some rural hospitals are a regional resource, providing the only full range of health services available for a large area. Often, other small proprietary hospitals offer limited services in the same region, but complex problems must be sent to the regional center.

Discharge planning in rural settings is often difficult. For example, one discharge planner we spoke with sometimes must find any responsible adult (e.g., a teacher, a minister) in the patient's community who is willing to check up on the patient regularly, since home health care services simply do not exist in some areas. Of course, the more complex the health care needs, the more difficult the discharge planning problems, and the elderly are likely to have more complex needs. Hospitals in rural areas must cut costs because of the prospective payment system, but must at the same time offer a full range of health care services without the patient volume to make it profitable.

Discharge planners in small rural hospital have additional problems. The prospective payment system almost requires that a hospital have fully computerized record keeping, and a sophisticated analysis unit that can spot areas in which the hospital is losing money. Larger urban hospitals have used this technology for some time, and although switching to the DRG system caused many problems, they already had the basic knowledge and equipment. Small rural hospitals generally did not have such systems, and are trying to catch up quickly. The expenditure for the equipment and new personnel is often difficult for a small hospital. In addition, discharge planning at many of these hospitals has been a part-time responsibility of a single worker. As discharge planning becomes more critical under prospective payment, small rural hospitals must rapidly change their discharge planning systems.

GENERAL DISCUSSION

Prospective payment for Medicare using diagnosis related groups (DRGs) has fundamentally changed hospital discharge planning for continuing care. The new system gives hospitals a strong financial incentive to make discharge planning efficient, and has given discharge planners greater visibility and influence in the hospital. It has also increased their workload and made it more difficult for them to systematically follow patients once they leave the hospital. Organizational changes in the hospital, such as vertical integration, also change the role discharge planners play in bridging different health care institutions.

According to our discharge planning respondents, the elderly have not suffered inordinately as a result of these changes so far. However, as the health care system responds to the pressure of prospective payment, several interacting factors must be carefully watched. Decreased census has caused many hospitals to market their services directly to the elderly, who are disproportionately high users of health care, but the DRG system may not adequately take into account their chronic medical problems and slower recovery rate. Hospitals thus have an incentive and a disincentive to take elderly patients. Changes in the structure of health care, such as hospital vertical integration, also have both positive and negative effects on the incentives to care for the elderly.

Because prospective payment is relatively new, and since the effect of the new enforcement mechanism for the system (the Peer Review Organization) is still not completely clear, the effect of prospective payment on care for the eldery is not certain. However, the data gathering and analysis being done on prospective payment should include the issues of discharge planning and continuity of care that are of special importance to the elderly.

I hope this discussion is useful in your investigation of this important topic. Please feel free to call on me for any additional information you may need.

Sincerely,

John Feather, Ph.D.
Associate Director

REPORT TO THE UNITED STATES SENATES
SPECIAL COMMITTEE ON AGING

COMMENTS REGARDING CURRENT
HOME HEALTH PRACTICE:
IMPACT OF MEDICARES PROSPECTIVE PAYMENT
SYSTEM ON DAVIDSON COUNTY HOME HEALTH

FROM: Barbara W. Jones
REPRESENTING: Davidson County Health Department
Lexington, N. C.

September 26, 1985

(1)

MEMBERS of the COMMITTEE:

I welcome being invited to speak to this Committee. We have seen both positive and negative effects on Home Health Services resulting from the implementation of Medicares Prospective Payment System. In discussing these effects with our colleagues involved in the home care field, we find that they are feeling the same effects.

I would like to share ten (10) aspects concerning this to the Committee.

POSITIVE ASPECTS:

(1) We are finding that situations can be managed in the home setting which were not managed in this manner previously. Frequently patients/families can handle problems which they or the medical system in the past did not feel they could manage, but with medical system support in the home the situation is manageable.

NEGATIVE ASPECTS:

(2) We are finding as a result of the implementation of the DRG'S, patients are now being discharged from the hospital with less teaching being done prior to discharge. The patients are too sick initially to be receptive to in-depth teaching. By the time teaching could be accomplished, the patient is discharged home. At this point home health services must start the teaching process. Often the patient/caregiver needs a great deal of intensive teaching initially. Since the home health staff does not stay in the home for extended periods of time on a visit, the patient/caregiver is not able to absorb all the necessary teaching until numerous visits have been made. During this time care is being provided without adequate teaching. This results in extra stress for the patient/caregiver and makes possible inadequate/negligent care being given to the patient. At the same time, the home health agency must be careful of frequency of visits as far as Medicare coverage is concerned. Medicare monitors these very closely.

A case history showing this situation is an elderly patient who was discharged from the hospital in the last days of his terminal illness. This patient came home with the following support devices: (1) Nasogastric feeding tube, (2) uninary catheter, and (3) continuous oxygen. The patient had skin breakdown at various sites also. The family had one demonstration of how to feed the patient prior to hospital discharge. No one had observed the family doing this to be sure they knew how. They had had no instructions in oxygen safety, skin care, catheter care, etc. The home health nurse had to meet the patient and family the afternoon of hospital discharge to begin this teaching. There was no way for the family to absorb all the necessary teaching in that afternoon. The nurse had to cover the most important points and hope that the family could handle the situation until her return visit the next day.

(3) Patients are being sent home much sicker than previously. This is fine if the home setting is adequate for the patients care - but at times patients are being sent home needing a tremendous amount of care. Patients who need intermediate level of nursing care in a hospital and those whom nursing homes will not accept due to the level of care they need are being sent home at times. The caregivers in these situations are very taxed by the care they must provide.

A case history showing this situation is a patient who was discharged home from the intermediate level of hospital care. This patient had a (1) tracheostomy, (2) was on a respirator, (3) needed frequent suctioning, and (4) chest percussion. He also had a gastrostomy feeding tube and a suprapubic urinary catheter. This patient's wife had had intensive teaching in the hospital but when the patient came home the care was overwhelming. The wife was the only available caregiver and the patient required twenty-four (24) hour care. At times he needed suctioning as frequent as every ten (10) minutes during the night leaving her totally exhausted. This wife is giving excellent care but it is definitely very taxing on her.

(4) We find patients are being discharged home so quickly at times that necessary equipment for patient care in the home is not obtained prior to the patient arriving home.

(5) Patients are being sent home into unknown or very questionable home situations as well as when the family readily states they do not feel they can provide adequate care. Physicians and hospital staff do not have time to adequately check out the home situation prior to discharge. Most patients sent home need a great deal of family support. If this support system is absent or inadequate, it is very difficult to get the patient readmitted until his condition deteriorates significantly. It is very frustrating for the home health staff to have to watch a patient deteriorate in these circumstances. Nursing home occupancy in our area is

eighty seven to one hundred per cent (87 - 100%) most of the time, so it is very difficult to place these individuals in a nursing home. We have had an increase in the number of referrals we must make to our local Department of Social Services due to inadequate home situations in the recent past.

A case history supporting this is a patient who was diabetic and retarded. She was discharged from the hospital to her home. This patient could not prepare her own meals and was left alone during the day hours. There was questionable family support. When the home health nurse initially saw the patient, she found that the patient was not eating (questionably had not eaten for several days) and her diabetes was uncontrolled. The patient had to be placed in a nursing home immediately to prevent even further deterioriation of her health status.

(6) We see very sick elderly patients being sent home from the hospital with an elderly spouse as a caregiver. Often the couple were barely able to meet each other's needs prior to the hospitalization. Now the situation is even worse. Due to our mobile society, frequently there is no other family support available.

A case history supporting this is an eighty four (84) year old female who was living with her ninety two (92) year old husband. The patient fell and suffered a vertebral fracture. She became bedridden, incontinent, and mentally confused. She was discharged home from the hospital with her husband responsible for providing care with the help of a daytime sitter. Even with this assistance, the elderly husband could not provide the other sixteen (16) hours of total care needed each day. The husband's health also began to fail as a result of the exhausting load he was carrying. The patient eventually had to be placed in a nursing home.

(7) At times patients are discharged from the hospital with home health services in their home being a criterian for discharge. Then as the patient's condition stabilizes he does not continue to meet Medicare's guidelines for home health services and these services must be discontinued. The patient/caregiver then are in a very bad situation.

(8) There is a lot of need for in home services which are not covered by Medicare's guidelines for home health. At times patients only need assistance with activities of daily living which could not qualify the patient for home health care. In the past these patients could have stayed in the hospital

until they could regain adequate strength to care for themselves if no one else was available to assist them. Now this is not possible.

(9) Sicker patients are being sent home from the hospital sooner now - needing more care. Yet, Medicare guidelines for home health care are not being broadened. In fact, there is frequent threat of impending further restrictions.

(10) Earlier hospital discharges are resulting in some potentially unsafe procedures being done in the home setting. A few examples of these are intravenous and intramuscular administration of antibiotics and intravenous administration of chemotherapy. While these procedures may be performed without any problems with many patients, the patients who do experience problems may have fatal results. Home health is a very competitive business at present and in order for a agency to continue to receive patient referrals they must try to meet the request of the referring physicians. If the agency refuses to provide the care, there are other agencies who will. Therefore, each agency feels pressure to do every procedure requested. Agencies are being forced into giving care which is against their better judgement. We feel physicians are being forced to practice administrative medicine rather than good sound medicine when they are pushed by the system into making these referrals. The results on the home health staff is the feeling that they are themselves providing poor care. Home health nurses especially are in a legal dilemma - morally they can't refuse service yet they know that adequate and safe care is not being provided. It is very difficult to leave a home knowing that the caregiver is uncomfortable with the care they must provide. These situations are very frustrating and cause a great deal of stress and anxiety for the home health staff as well as the caregiver.

Statistics will not give you the true picture of what is happening to patients with the system now. Early discharges at times are resulting in human suffering. Both patients and their families are being affected. Patients are not getting adequate care and families are pushed to the point of exhaustion. In addition, they are often thrown into situations with inadequate preparation, resulting in additional stress to them. While Medicare Prospective Payment System has shown that many patients can indeed be managed safely at home, there are still people suffering from the system. If the system continues, it seems there should be some mechanism for granting exceptions - especially prolonging hospital stays and allowing easier admissions to hospitals in situations where this is needed.

Again, I would like to say that it has been a pleasure sharing our thoughts and ideas with you. I will be glad to try to answer any questions or clarify any statements.

VISITING
NURSE
SERVICES

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October 16, 1985

Senator Heinz
U.S. Senate
S D - G 33
Washington D.C. 20510

Dear Senator:

As a health professional working with terminally ill patients, I have become increasingly aware of the negative impact of the new Diognostic Related Groupings upon our patients. We are seeing patients who are released sooner from hospitals, are much sicker when they come home and lack adequate instruction in their care needs because of their hospitalization is abbreviated. At the same time, Medicare home health provision is limited to intermittent care and is pressuring home care providers to decrease the time spent teaching in the home. The seriously ill person and his family or caretaker are being forced to make sophistricated judgements about symptom management, use of high technology equipment, when and whether to contact physicians and care goals with ever decreasing community support.

Dealing with cancer patients I am seeing people who are receiving agressive chemo-therapy and radiation treatment sent home with little or no family support. The patient is too weak to provide himself with adequate food or fluids thus negating the potentially positive effects of his cancer therapy. We as a nation have committed ourselves to continued research and treatment of diseases such as cancer. Without adequate home health support and the co-ordinated care of in-patient facilities as a back-up, treatment often leads to more suffering and debility for the patient without the resources to manage his care safely. I will relate some of the patients I have worked with who have fallen thru the "cracks" of the DRG system.

S was a 16 year old patient who was treated with surgery and radiation for cancer of the bowel. He was sent home to die with his wife of two years as primary caretaker. His wife was told he couldn't be admitted to the hospital again since he had overstayed his DRG thru previous hospitalization. His wife became extremely stressed by his care but felt she couldn't afford a nursing home because of limited income. His condition deteriorated rapidly, on a Saturday, he became incontinent, pain was out of control and he began to hallucinate. His wife felt powerless, didn't notify the M.D. or R.N. on the case but simply abdicated his care by closing the bedroom door. On Monday the visiting nurse found him in a saturated bed, moaning, unable to tolerate even being touched because of his extreme pain. He was then admitted to the hospital and died one day later. Nursing home placement was being instituted even in his immenitally terminal state because of DRG, but death intervened.

W was a 63 year old patient with terminal cancer of the ovary with wide spread metastasis to the bowel. Extreme weakness and frequent bowel obstruction with increased pain and nausea and vomiting were a continual problem. Patients caretaker was her 74 year old husband who was debilitated by Parkinson's disease. Family had recently moved to this area and had very little community support. W obstructed partially with increased symptoms as described. Her physician was reluctant to hospitalize even though she was not on Medicare but had private insurance because he felt she would "cause his charts to be reviewed for 6 months by utilization review committee DRG's". Patient's husband's health deteriorated to such an extent that he was no longer able to care for her. She was then hospitalized paid for by private insurance and died while in the hospital one month later. Unfortunately for this family a crisis pattern had to be utilized to gain this woman medical support.

T was a 66 year old man who was ill for five (5) years with lymphoma of the central nervous system. He was treated aggressively with chemo-therapy and radiation, had a venouse access device (Hickman cath) and a ventrical port implanted in his skull for chemo. He was hospitalized because of increased weakness, confussion and combrative behavior. As he became sicker, discharge plans were made to send him home with highly technical IV's and possible IV pain medication. His wife, who couldn't even move him alone, was over whelmed. Since he had a Hickman catheter he wasn't eligible for a bed ~~at~~ any of the local nursing homes. The nursing homes felt they couldn't manage this patient but his wife was expected to do it alone after two days of in hospital teaching.

A is a 76 year old patient who was diagnosed with cancer of the lung after being hospitalized for pneumonia. She was sent home after beginning radiation therapy because of DRG limits on her stay in the hospital. Her husband is non-functional with a psychiatric impairment and lives in the basement of their single family home. A was his primary caretaker for 14 years. Her daughter lives 60 miles away but a Home Health Aide was hired privately to care for her eight (8) hours per day. She became sicker since her debilitating weakness an shortness of breath prohibited her from obtaining adequate food or fluids. She was taken by stretcher to radiation treatment and was re-hospitalized because she had deteriorated so quickly over a weekend period. She recovered in the hospital with adequate hydration and nutrition and was able to continue therapy.

These cases may give you an idea of what is happening to people who are not supported adequately thru hospitalization even as home health care is being limited. Patient's must become sicker, experience crisis and then receive attention. Cost effectiveness with DRG's is costing inhuman suffering.

Bernice Lazar

Bernice Lazar/RN
Transition Services
The Visiting Nurse Services

STATEMENT

of the

COALITION ON MEDICARE AND MEDICAID REGULATIONS

submitted to the

UNITED STATES SENATE

for its Hearing on

MEDICARE DRG's: CHALLENGES FOR POST-HOSPITAL CARE

October 24, 1985

Contact: Betsy Vourlekis
National Association of
Social Workers
7981 Eastern Avenue
Silver Spring, MD 20910
301/565-0333

The Coalition on Medicare and Medicaid Regulations, a coalition of some 25 advocacy and provider groups, is pleased to have the opportunity to comment on the issue of hospital discharge planning and Federal regulatory efforts with respect to discharge planning, in connection with the October 24, 1985 hearing on "Medicare DRG's: Challenges for Post-Hospital Care" held by the Senate Special Committee on Aging.

INTRODUCTION:

The adequacy and appropriateness of hospital discharge planning is a critical feature of the quality of care provided under the current Medicare Prospective Payment System. With powerful financial incentives existing for hospitals to release patients as quickly as possible, the existance of a professionally coordinated, and highly skilled discharge planning process is crucial (1) to assure that discharge planning occurs on behalf of the patient and not as a mere convenience to the institution and (2) to guarantee that medical needs and medically-related social and emotional factors in the patient's condition are fully considered in the plan for and decision to discharge.

The Coalition believes that the Administration's proposed new Conditions of Participation for Hospitals in Medicare and Medicaid are inadequate in their coverage of many areas of patient care. The proposed Conditions, in de-credentialling personnel in many program areas, provide additional incentives to hospitals to focus on financial and cost-cutting measures rather than the quality of patient care. The imposition of these new conditions at a time when we have increasing evidence of patients being discharged "quicker and sicker" would, we believe, seriously weaken hospital discharge planning.

The Coalition believes that Federal Standards and oversight authority with respect to discharge planning are essential. Neither the existing Conditions nor the proposed conditions adequately address the responsibility of hospitals to ensure the well-being of Medicare-Medicaid patients through a continuum of care. Any new Conditions should incorporate existing fundamental principles of discharge planning which have been developed through extensive professional experience.

A FRAMEWORK FOR ADEQUATE STANDARDS FOR DISCHARGE PLANNING

With the implementation of the Prospective Payment System and DRG's, discharge planning has become an increasingly critical component of hospital care. Financial incentives to hospitals to shorten length of stay result, in many cases, in patients going home sooner and in a more vulnerable condition then they did under a system of retrospective reimbursement. Nevertheless, hospitals retain the responsibility to meet statutory requirements of Medicare-Medicaid to assure patients access to adequate health care.

The goal of discharge planning should be to facilitate the patient's transition from the hospital to a safe environment which adequately meets medical and medically-related social and emotional needs. Quality discharge planning in the hospital is crucial to assuring continuity of care for patients. And yet testimony before this Committee has demonstrated that hospitals are using discharge planning as a warning system for and convenience to the financial office.

Discharge planning is a complex function requiring (1) early screening and assessment of needs; (2) patient and family education and counseling; (3) identification and development of resources and (4) coordination of input from many professional disciplines. Quality discharge planning requires an understanding of and skill in dealing with social and emotional aspects of illness, for both the patient and family, as these are frequently critical factors in either enhancing or impeding the safety and adequacy of post-hospital care arrangements.

The Coalition strongly believes that any effort to change the existing Conditions of Participation with respect to Discharge Planning must reflect certain basic principles and guidelines. Discharge planning must be understood as a critical, complex and demanding function requiring professional level skill and training. The following principles for good discharge planning are presented.

- Discharge planning is a service which exists to meet the patient's and the patient's family's needs (including the need for information) as well as to improve utilization of hospital resources.
- Discharge planning should, to the maximum extent possible, be done with the patient and the family and not to or for them.
- Discharge planning is an inter-disciplinary, hospital-wide process and responsibility for its coordination must be assigned.
- Responsibility for all aspects of discharge planning, including provision for meeting medically-related social and emotional needs and overall coordination, must be lodged with professionally trained personnel.
- A discharge planning program should contain the following essential elements:
  - Patient advocacy (including provision of information on options and rights and maximum feasible patient participation decision making).
  - Early screening/assessment of post-hospital care needs.

- Coordination of multi-discipline input which results in a discharge plan.
- Patient and family counseling and education.
- Identification and development of appropriate community-based resources.
- Patient post-discharge follow-up.
- Monitoring of the effectiveness of the discharge planning program.

Standards for Discharge Planning in the Proposed Conditions of Participation

This analysis is based on the latest proposed version of the Conditions available to us (December 12, 1983). While we understand that HCFA has been re-working this, neither we, nor to our knowledge, Congress has seen a new version at this time.

In the Proposed Conditions, all reference to discharge planning is contained in a new sub-section of the Quality Assurance Standard (482.21). The Standard, "Medically-related patient care services", requires an "effective, on-going discharge planning program." The only elements of this program delineated in the standard are (1) that it be timely and (2) that patients "must be transferred and referred to appropriate facilities, agencies, or out-patient services, as needed, for follow-up or ancillary care."

The proposed Conditions are inadequate in their treatment of discharge planning for the following reasons:

- While discharge planning is mandated as a program, the placement of the standard within the quality assurance standard is a peculiar and illogical choice. Every other program component, from budget operations to radiology, is dealt with as a separate entity. All program elements are subject to Quality Assurance evalutation and this should include discharge planning. Discharge planning is critical to quality assurance. However, in its "tacked on" position in the Quality Assurance Standard, the program is treated as an afterthought, organizationally adrift, with no explicit accountability as a distinct function which needs to be monitored and evaluated in its own right.
- The Standard gives minimal indication of the scope and functions expected of the discharge planning program. Such indications as there are do little more than suggest that discharge planners must get people out fast and must put them where it is most expedient to put them.

- The standard makes no mention of follow-up of discharge patients, coordination with community resources, or other crucial continuity of care issues.

Viewed in the context of the overall emphasis on de-credentialling of personnel is the Proposed Conditions, the proposed standard on discharge planning is weakened even further. Given that discharge planning is critical to hospitals under DRG's, the de-credentialling of discharge planning functions provides further incentive to hospitals to use discharge planning as part of their financial operation rather than as a professionally conceived, organized and delivered patient care service.

Standards for Discharge Planning under the Existing Conditions of Participation

Because of DRG's, hospitals are increasingly emphasizing discharge planning. A new condition mandating discharge planning is not necessary to make this happen. The critical issue, then, is not simply the existence of a discharge planning program, but rather the nature, quality and purpose of such a program. The current Conditions do need to be strengthened with respect to discharge planning. However, as they stand, they, at the very least, do not provide further incentives to Hospitals to compromise quality of care to financial considerations.

The existing Conditions of Participation do not have a specific standard for discharge planning. Reference to discharge planning functions (e.g. helping patients make full use of out-patient, extended care and in-home health services in the community) are contained in the Standard for the organization and provision of Social Work Services. Follow-up of discharged patients and cooperative activities with community agencies are required functions for social work.

In addition, the existing Standard concerning utilization review states that reviews of length of stay "might consider" the availability of assistance to the physician in arranging for discharge planning as well as the availability of community resources which would assure continuity of care.

The current Conditions are inadequate with respect to discharge planning in the following ways:

- Discharge planning is not highlighted and delineated as a specific program component, nor are key elements in its successful provision (as for example, the importance of coordination of efforts) recognized.

- Discharge planning functions are assigned to social work, but the Condition concerning provision of Social Work Services is not a mandatory one. Hospitals are not required to have social work departments or personnel to participate in Medicare/Medicaid. If they choose to, then they must satisfy the Condition.

- The language of the utilization review standard suggests that examination of critical issues of continuity of care are optional.

Conclusion

It is the view of the Coalition that the Proposed Conditions of Participation, taken as a whole, constitute virtual deregulation of the health care delivery system and that such deregulation poses threats to quality of care in many areas. The area of discharge planning is just one such area. The existing Conditions of Participation for Hospitals do not pose a similar threat. We continue to believe that the process to develop new conditions, including fully adequate standards for discharge planning, should be an open one, involving Congress, and allowing for maximum input in considering useful standards.

We want to thank members of the Special Committee for the opportunity to share our views.

Elmhurst Extended Care Center, Inc.

"WHERE SOMEONE CARES"

200 E. LAKE STREET • ELMHURST, ILLINOIS 60126 • TE 4-4337

United States Senator
Honorable John Heinz,
Chairman of the Senate Aging Committee
Room G 87 Dierksen Building
Washington, D.C. 20510

October 31, 1985

Dear Senator Heinz,

I am very pleased with the news that your committee is reviewing the removal of Medicare benefits from the elderly. I am writing as a witness to this fact which has distressed me greatly since October, 1984. During this one year period I have witnessed a fine program turn to no program at all!

I have watched my facility's rehabilitation programs which annually admitted an average of 250 patients, returning between 50% to 70% of these people back to home and community change to a program in which the patients are so ill that 1 year ago the majority of patients would be in an acute hospital setting and all rehabilitation programs be denied benefits. In this 1 year the diagnosis of "fractured hip" has been removed from benefits, skilled observation for congestive heart failure and, myocardial infarction removed from benefits, Stage #3 decubitus extremity ulcers removed from benefits, nasal and gastric feeding tubes removed from benefits, stroke victims removed from benefits when improvements could not be documented daily, and full body cast patient denied benefits. There are many, many other adverse decisions. All this after a 17 year history of coverages.

Sir, the closest analogy I can draw to relate to this situation would be for the U.S. government to destroy all the county's law books, thereby removing all references, protocol, and precedent without notice and then expect the courts to continue working.

My staff and I resent being the pawns to communicate these reductions in benefits as no communication has been given to the elderly of our county. But, we can adjust. We can simply not cover these sick old people, based on our current denial experience, which we have no right to appeal. The beneficiary only has the appeal right, but without medical expertise, this is no right at all. But what about the elderly. They have no knowledge to adjust to, they think they have "Medicare."

I have enclosed 24 adverse coverage cases, 22 by our fiscal intermediary, Aetna Life & Casualty, and 2 by Maxicare as backup for my letter.

Even though we used the word "appeal" in each case and the dollars were removed from the facilities reimbursement, we were informed that we could only request a "review". No reason why the patients were non-covered other than "no skilled care" was ever stated.

As the industries base for historical decison making has been arbitrarily removed, I suggest 1 of 2 procedures to correct this situation.

1) Advise facilities of the criteria for review by the intermediaries so the same decisions can be arrived at. There is no written criteria now, or:

2) Install professional review committees to set coverage with limits prior to admission to a skilled nursing facility. These committees could be hospital based as there is still a 3 day hospital stay requirement.

Sir, at your committee pleasure, and with the patients (beneficiaries) authority, I would be pleased to present detailed medical records to your committee.

Respectfully submitted,

John Massard

John Massard
Administrator

JM:da

CALIFORNIA MEDICAL REVIEW INC.
1388 SUTTER STREET • SUITE 1100 • SAN FRANCISCO • CALIFORNIA 94109 • (415) 923-2000
WILLIAM H. MONCRIEF, JR., M.D. *President*
JO ELLEN H. ROSS *Executive Director*
CMRI

November 13, 1985

Ms. Beth Fuchs
U.S. Senate Special Committee on Aging
SD-G33
Washington, D.C. 20510

Dear Ms. Fuchs:

As we discussed last week, enclosed is testimony from Eva Skinner for the U.S. Senate Special Committee on Aging's hearing held Tuesday, November 12. This written testimony is to be included in the official record of the hearing.

If you have any questions, please feel free to call me at (415) 923-9209.

Sincerely,

Sharon Ahern

Sharon Ahern
Professional Relations Coordinator

Testimony of
EVA SKINNER
submitted to the
U.S. SENATE SPECIAL COMMITTEE ON AGING
November 12, 1985

Testimony of
EVA SKINNER
submitted to the
U.S. SENATE SPECIAL COMMITTEE ON AGING

Senator Heinz,

My name is Eva Skinner. I am one of California's nearly three million Medicare beneficiaries. I am here today to give you my perspective on Medicare Peer Review Organizations and the role of PROs and the federal government in assuring quality health care for the nation's elderly.

Although I am just one of millions of Medicare beneficiaries nationwide, I bring a broad perspective to the issue you are discussing today. For more than 45 years I worked as a registered nurse. I have been active in health care issues affecting senior citizens in California and nationally for more than two decades. I am also an active member of the American Association of Retired Persons and currently serve on the national advisory board of the Gray Panthers.

In addition, I am one of two Medicare beneficiaries serving on the Board of Directors of California Medical Review, Inc., the California PRO, and one of only eight Medicare representatives currently serving on the 54 PRO boards nationwide.

Since the inception of Medicare's Prospective Payment System, I have been deeply concerned about the quality of health care services provided to Medicare beneficiaries. I have been watching the PROs with great interest to see how they identify and address quality of care problems. Through my work with California Medical Review, I can say that I am pleased with the serious intent of this PRO and the commitment of its staff and physicians to render quality health care while working to reduce unnecessary hospitalization and costs under Medicare. However, much more needs to be done in the area of quality assurance by the federal government and PROs nationwide.

In particular, California Medical Review is setting a good example of quality assurance activities other PROs should be initiating. Last month, after thorough and careful investigation, CMRI recommended to the office of Inspector General of the Department of Health and Human Services that three physicians and one hospital be sanctioned for providing inappropriate or substandard care to Medicare patients.

These recommendations, among the first in the country, have established a precedent for PROs nationwide and sent a warning to the hospital and physician community that PROs are serious and committed to maintaining quality health care delivery despite mounting pressure on the part of the federal government to control skyrocketing health care costs.

The response from the Office of the Inspector General will reinforce the message that hospitals and physicians will be held accountable for their action or inaction. California Medical Review is currently finalizing more than 20 additional sanctions and expects its review activities to produce another 100 sanctions by the end of 1986.

Education is another quality assurance activity being conducted by California Medical Review that needs to be emphasized in all state PRO programs and by the federal government. Acronyms such as PPS, DRGs, HMOs and PPOs remain alphabet soup for the majority of our nation's senior citizens. The bottom line is that seniors need to know their health care rights and how changes under the Prospective Payment System affect their health care delivery to avoid becoming victims of compromised care.

To better educate California's Medicare beneficiaries, California's PRO recently released guidelines to local media outlets as well as federal and state legislators outlining questions Medicare patients and their families should ask their physicians and hospital representatives. The purpose of these guidelines is to enhance quality of care, avoid premature discharges, plan for care after hospitalization and, in general, encourage patients to become partners in responsibility for their health care. In addition, California Medical Review's staff, local physician-employees, Board members, and I have been conducting outreach to senior citizen groups throughout the state to further educate them about the Medicare system and their rights as Medicare patients.

In addition to CMRI's efforts, the Gray Panthers recently released guidelines to senior groups throughout California and the American Association of Retired Persons has compiled an excellent booklet titled Knowing Your Rights which has been distributed nationwide.

While these educational programs are to be commended, the federal government cannot continue to rely solely on senior citizen groups and Peer Review Organizations to educate the public about the government's health care delivery system. To better educate the nation's senior citizens about health care under Medicare, I urge the federal government to: establish a national toll-free Medicare informational "hotline" to give beneficiaries immediate access to needed Medicare information; require hospitals throughout the country to provide standardized information to senior citizens, upon admission, detailing their health care rights under Medicare; and, provide regular updated information on Medicare services and care using inserts with Social Security checks.

In addition, the federal government, hospitals, doctors and PROs must provide seniors with consistent and accurate information about Medicare.

On the national level, there must be a greater commitment on the part of the Department of Health and Human Services for adequate funding of state PROs to help reinforce, strengthen and expand their mandated quality assurance authority in sanctioning hospitals and physicians providing inferior or substandard care.

All PROs have the ability to sanction, yet after more than a year's operation only two PROs have recommended sanctions to the Office of the Inspector General.

The members of the organizatons I represent are quite aware of this committee's concerns about premature discharges. The Health Care Financing Administration has made strides toward reducing the incentive for hospitals to apply pressure for early hospital discharges by instructing PROs to deny payment to a hospital for a second admission that results from premature discharge.

I encourage the federal government to continue working to prevent hospitals from pressuring physicians to discharge patients too soon and to increase support by the federal government for research and more effective quality controls at the PRO level for identifying, assessing and preventing a broad range of quality of care problems.

In addition, as cost containment pressures drive more and more patients from hospital beds into nursing homes and other outpatient care facilities, it is critical that PROs be given greater authority and funding by the federal government to review patient care in these facilities -- beyond the corridors of the hospital.

Preadmission certification for skilled nursing facilities as well as additional planning and funds for community based services such as home health services for personal care, transportation and meals for the post-discharge patient are also needed to assure quality care and effective use of health care resources. As a result of early discharges, elderly patients are often channeled into skilled nursing facilities whether or not that level of care is needed. If proper planning and post-discharge levels of care were available in this country as they should be, the increasing number of elderly patients sent to nursing homes would be reduced dramatically.

Most important, Medicare beneficiaries need to be involved at the local, state and federal levels in Medicare and PRO policy development. Toward this goal, I urge PROs to act upon a nationwide drive underway by AARP to have Medicare beneficiaries serve on all PRO boards. While consumer advisory panels could provide valuable input, greater representation of beneficiaries on PRO Boards will give Medicare patients a voting presence on issues that critically affect their lives.

I know I speak for the more than 27 million seniors enrolled under Medicare nationwide in this country in saying that we want and deserve to be involved in protecting our access and right to quality health care now and in the future.

Thank you.

UNIVERSITY of PENNSYLVANIA
PHILADELPHIA 19104

School of Nursing

Nursing Education Building/S2
(215) 898-8281

13 November, 1985

Beth Fuchs
Coordinator of Health Team
US Senate Select Committee on Aging
G-33 Dirksen
Washington, DC 20510

Dear Ms. Fuchs:

I am pleased to be invited by Mary Naylor to submit testimony to the Senate Select Committee on Aging regarding quality of care issues for Medicare recipients in nursing homes. I hope the enclosed remarks will be of use to the Committee in its work.

Sincerely,

Lois K. Evans

Lois K. Evans, RN, DNSc
Assistant Professor

LE/aw
enc.

UNIVERSITY of PENNSYLVANIA
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13 November, 1985

Senator John Heinz, Chair
Senate Select Committee on Aging
Washington, DC 20510

Senator Heinz:

I appreciate this opportunity to present testimony regarding the impact of DRG's on quality of care for Medicare recipients in long term care. My recent experience as a director of nursing in a 180-bed skilled and intermediate care facility and as project director for one of the eleven Teaching Nursing Homes in the Robert Wood Johnson national demonstration project, as well as my current faculty role in the Gerontological Nurse Clinician program at the University of Pennsylvania all serve to heighten my awareness of the many issues surrounding quality of care in nursing homes. I will limit my remarks to three areas:

- changing intensity of long term care case-mix
- staffing discrepancies
- special concerns of hospital-based nursing homes

1. Changing intensity of long term care case-mix. Recent data suggests that today's nursing homes serve patients with a wide range of care needs. About half of these patients stay under six months and require short term rehabilitation, recuperative nursing services, or short term terminal care. The remaining patients need maintenance and sustenance over a long time period, most until death.

For all patients in nursing homes, however, the intensity of care level is increasing. Nurses report a need to care for a new classification of patients - the "super-skilled," "semi-acute," or "special-skilled" patients who require an exceedingly high intensity of care. The trend toward managing patients longer and for more illnesses in the nursing home versus transferring them to the hospital for treatment of such problems as urinary tract infections and pneumonia requires increased use of skilled technologies, e.g., administration of IV antibiotics. In addition, the admission into the nursing home of patients requiring such technologies as respirators, total parenteral nutrition, and chemotherapy drastically changes the case-mix of the nursing home population.

One concern recently expressed by directors of nursing is that not only are they being asked to accept sicker patients, but their own patients who have experienced a hospital stay are returning to the nursing home in considerably frailer condition, with evidence of poor hygiene and nutrition and/or with inappropriately treated conditions (e.g., high fever, infected wounds). Such inappropriate discharges to nursing homes require immediate transfer back to the hospital, an event which unquestionably contributes to increased mental confusion, lowered resistance, and increased mortality in this frail elderly group.

2. Staffing discrepancies. The changes expected of nursing service - professional monitoring and managing acute illnesses, use of sophisticated technologies in treatment, and providing for needs of special groups of patients - are not conceptually inappropriate for a long term care facility. It is at the level of implementation, however, that safety and quality of care issues must be addressed. Even the most exemplary nursing homes are by design (and licensure) nursing homes, not hospitals. Currently reimbursed staffing levels (i.e., minutes of care in 24 hours) and mix (i.e., RN to LPN to Nursing Assistant) reflect this fact and preclude safe, effective delivery of the type of care required by this changing mix of patients. Moreover, while nursing is purported to be the basis of care in nursing homes, the bulk of direct care is actually provided by aides or non-licensed personnel. Nationally, there is only one RN per 100 patients in a nursing home in contrast to one RN per 4.5 patients in acute care facilities. Furthermore, federal regulations require only that skilled nursing facilities provice 24 hour service by licensed, not Registered, nurses and mandate the service of one RN only during the day tour of duty five days per week, further limiting the incentives for nursing homes to increase their professional staff. Such disincentives continue in the face of recent studies which demonstrate the strong relationship between professional nursing staff and quality of care in nursing homes.

Another reality which affects the ability of current staff to adequately provide additional skilled services is the fact that, on the average, nursing home nurses are older, have had less continuing education, and are more isolated from their peers in the mainstream of health care. The recent attention to this factor in two national programs - Robert Wood Johnson Teaching Nursing Home Program and Kellogg Foundation Project Practice for Nurse Administrators in Long Term Care - will help, but change will occur only incrementally. The introduction of masters-prepared gerontologic nurse practitioners/clinicians and clinical specialists will also facilitate provision of more sophisticated levels of care; however, the employment of these master clinicians in nursing homes remains at present more the exception than the rule.

One final concern relates to the allocation of finite resources. Given the need for increased professional nursing time for the sicker patients, there is increasing danger that frail, but less acutely ill, patients, especially those with mental impairment, will be inadvertently neglected. Obviously, then, with the increasing intensity of patient care needs and the concomitant absence of on-site medical personnel, nursing homes must have sufficient numbers of professional nurses on site capable of making high level clinical decisions, providing sophisticated assessments and nursing interventions, and administering a unit to assure safe and effective patient care.

3. Hospital-based nursing homes. In addition to the aforementioned problems currently experienced by free-standing nursing homes, hospital-based facilities are experiencing additional concerns regarding intensity of case mix. Administrative pressure to help decrease DRG days by providing pre-op care, receiving fresh post-op patients or accepting greater numbers of "heavy care" or "special-skilled" patients than can be safely care for are being reported by these sites. The movement of many hospitals toward converting and licensing an underused in-house unit for extended or skilled nursing care or acquiring (or developing strong affiliations with) a nursing home is quite a temptation for hospitals since one in four nursing home patients are hospitalized each year. Hospital-

based nursing homes which provide "subacute care" frequently alter staff mix to provide additional RN time (for instance, the one which which I am familiar provides an average of 54 RN minutes in 24 hours, as compared with the 12.5 national average); this option, however, is limited due to allowable reimbursement mechanisms.

Recommendations. There clearly is a need for systematic data collection regarding the changes in and experiences of nursing homes in this area. A nursing monitoring system should be developed which would 1) certify appropriateness of a patient's discharge to a skilled nursing facility; 2) monitor the experience of the patient in the skilled nursing facility; and 3) monitor the level of care being provided in the nursing home prior to hospital transfer (as in the pre-op situation).

In addition, realistic changes in reimbursement for staffing nursing homes to improve the mix of professional to non-professional staff is essential. Concurrently there is a need to enhance the knowledge and skills of nurses practicing in nursing homes.

Thank you for your consideration.

Lois K. Evans

Lois K. Evans, RN, DNSc
Assistant Professor of Nursing
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LE/aw

People's
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STATEMENT

of the

PEOPLE'S MEDICAL SOCIETY

to

SENATE SPECIAL COMMITTEE ON AGING

on

THE MEDICARE DIAGNOSIS RELATED GROUP/PROSPECTIVE PAYMENT SYSTEM AND ITS IMPACT ON THE QUALITY OF MEDICARE BENEFICIARIES HEALTH CARE

November 14, 1985

Presented by:

Charles B. Inlander
Executive Director

Mr. Chairman. My name is Charles Inlander and I am Executive Director of the People's Medical Society. As the nation's largest consumer health organization, with over 85,000 individual members, I want to thank you for your invitation to provide this statement of the views of the People's Medical Society on the Medicare DRG/ Prospective Payment System and its impact on the quality of Medicare beneficiaries health care.

The People's Medical Society has been a strong advocate of the Prospective Payment System. In theory, the Prospective Payment System may be part of the "safety net" we have all heard so much about for senior American's faced with health problems.

At the same time, the People's Medical Society, just three years old, has become one of, if not, the most outspoken critics of the lack of quality care and safety found in many of our nation's hospitals.

In fact, one of the reasons we strongly supported the DRG system is that it took away the incentives for unnecessary procedures, length of stays, and admissions. It is our contention, and it is borne out in the medical literature, that the longer one remains in a hospital, the more likely they will suffer the effects of a nosocomial infection or an iatrogenic incident. With a well monitored and controlled DRG system many of these hospital caused problems would be eliminated for America's senior citizens.

However, today we would like to focus our statement on a cruel irony that appears to be occuring as a result of the implementation of the DRG program.

As testimony before this Special Committee has identified, many thousands of elderly Americans are being prematurely discharged, or "dumped"(to use a long standing term of medical slang for such an occurance) from hospitals in too sick a condition to care for themselves or be cared for by their families.

While the testimony varies as to the degree to which this is occuring, the figures used by the Health Care Financing Administration appear to be only the tip of the iceberg.

From the membership of the People's Medical Society we have received well over 100 calls and letters from persons who believe that either they or a family member has been released too soon from the hospital. All of the people in question were Medicare beneficiaries. And, let me add, we did not solicit these calls or letters.

The irony is that the system was developed to encourage efficiency. It was designed, among other reasons, to get people out of the hospital faster and with less useless and needless things happening to them.

The cruelty, though, is that some hospitals appear to be "dumping" people in the name of profits, or greed, long before they are medically ready to be discharged. This, no matter what the incentive, is the making of a national scandal.

This Special Committee is fully aware of the significant drop in the average hospital census since the implementation of DRGs. This Special Committee is also aware that the hospital industry fought hard and long to block the implementation of the DRG system. Many members of this Special Committee heard hours of testimony over the past few years, the hospital industry's equivalant of hanging crepe, about the demise of hospitals if a DRG system were implemented.

Yet, in the first quarter of 1985, the profits of hospitals rose 22% over the first quarter of 1984. This represents the biggest profit margin increase in the first quarter since the American Hospital Association began tracking such statistics in 1963.

There is certainly nothing wrong or un-American about such profit increases. But, the People's Medical Society finds it quite a difficult pill to swallow when one is told, just a little over 12 months ago, that the system which has given rise to such increases is in fact a demon that will mean the demise of the hospital industry.

The People's Medical Society also finds it quite hard to believe that such profits were generated solely because hospitals have become more efficient purchasers of services.

The evidence clearly suggests that a great deal of this profit has come at the expense of Medicare beneficiaries being discharged prematurely -"dumped"- from their hospital bed.

Mr. Chairman, we have had the opportunity to review a great deal of the testimony that has been presented to this Special Committee. We know that many experts and other citizen organizations have expressed their concerns about many different aspects of the PPS and DRG programs. We are not presenting our statement to repeat those other groups. In fact, our purpose in providing this statement is to offer a solution to the premature discharging of senior Americans from hospitals.

When this problem first began to appear, the People's Medical Society began an inquiry into the protections senior citizens had from being discharged prematurely under the law.

We began our inquiry with the Health Care Financing Administration. From HCFA, we received a question and answer sheet that provided some information, but not a great deal. We went further. We went to the laws governing the program itself and what we found were that Medicare beneficiaries had rights to appeal a proposed discharge, had a certain number of days of no liability while an appeal was in process(even if ultimately found in favor of the hospital), and had the right to remain in the hospital, at their own expense, if the appeal decision was not in their favor.

The above took over three days to find. It took us just two hours to put these rights into a 5 part statement that citizens could understand. Why we wondered had not HCFA done this?

It became clear to us that almost all Medicare beneficiaries were unaware of their rights. If HCFA had not put them into a format which we could easily understand, how would an elderly, ill American know his or her rights of discharge.

But, we did not want to assume that just because we had trouble finding out about Medicare discharge rights that the average Medicare recipient would encounter the same problem. So we decided to call each of the ten(10) regional HCFA offices throughout the country.

One of our People's Medical Society staff members called each of the regional HCFA offices indicating that their elderly parent, a Medicare beneficiary, was being told they had to leave the hospital. She asked what her parent's rights were. The answers were staggering.

First, all ten offices gave different answers. Only one of those ten answers was correct. Even more amazing was that several of those who gave wrong answers told us they did not know offhand and would have to get back to us. When they did, their answers were wrong.

It became more and more clear that citizens did not know their rights. It became more disturbing because we know from our own experience that if citizens are armed with their rights they will not only exercize them, but those who might deny them of their rights will be less likely to do so.

It disturbed us for even more reasons. In this country we require that every person arrested for a criminal act be "Miranda-ized", advised of their rights. Yet, unsuspecting senior citizens are being "dumped" from hospital beds without being advised of their rights to appeal. And, more alarming, the hospitals who are doing it are making greater profits off of tax payers dollars.

The People's Medical Society felt that every Medicare recipient should be aware of their rights. To this end, we took the following actions:

1) We asked Secretary Margaret Heckler of the Department of Health and Human Services to send a letter to all Medicare recipients advising them of their rights of discharge under the DRG system.

2) We asked the Health Care Financing Administration,

through a letter to Mr. C. McLain Haddow, Acting Director, to promulgate a rule that would require every hospital to give every Medicare beneficiary a copy of their Medicare hospital discharge rights, in writing, at the time of hospital admission.

As of this date we have not received a response from those individuals.

Copies of those documents are attached to this statement.

Members of the Committee, the "dumping" of elderly Americans could be significantly reduced, if not completely stopped, if Medicare recipients knew their rights. Certainly, such simple and easy steps would nip this problem before it gets beyond the level of repair.

Indeed, there are many parts of the DRG system that need review and correction. Much of this will have to be done legislatively. The vast majority of the problems that exist are actually between the federal government and hospitals.

But the problem of elderly Americans being discharge prematurely pales all other problems. If the Medicare beneficiaries become the pawns of the profit motive of certain greedy hospitals all of the fine points of the DRG system will be lost.

And, if the federal government fails to use its own agencies to see to it that providers of service advise people of their rights, the system will be lost.

Members of the Committee, the People's Medical Society urges you to support our efforts to require hospitals to inform people of their discharge rights under the Medicare system, in writing, at the time of admission. The campaign we have launched on this matter is of vital importance to elderly Americans.

We also ask you to consider these measures in any legislation you introduce as a result of these hearings.

Elderly Americans should not and cannot wait while government officials argue over how many persons were discharged prematurely. Elderly Americans will not be satisfied with offending hospitals being reprimanded after the fact.

There is no policing or review organization big enough to monitor this situation. But, the recipient of Medicare benefits and his or her family can and will if they are aware of their rights.

We very much appreciate the opportunity to provide the views of the People's Medical Society on this most important subject.

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December 17, 1985

The Honorable John Heinz
Chairman
United States Senate
Special Committee on Aging
G-33 Dirksen Senate
Office Building
Washington, D.C. 20510

Re: Hearings on the Impact of Medicare's
Prospective Payment System of the Quality
of Care Received by Medicare Beneficiaries

Dear Chairman Heinz:

On behalf of Glasrock Home Health Care, Inc. ("Glasrock") enclosed please find Glasrock's Prepared Statement to the Special Committee on Aging of the United States Senate concerning the impact of Medicare's prospective payment system on the quality of care received by Medicare beneficiaries. Glasrock submits the enclosed statements to supplement the testimony before your Committee during hearings held on September 26, 1985, October 24, 1985 and November 12, 1985.

As you will note from the enclosed, Glasrock is a full service home health care equipment firm specializing in providing respiratory therapy and durable medical equipment to the public. Glasrock is the nation's largest provider of home health care equipment maintaining 248 outlets in 38 states from which it services the full range of home health care consumers including Medicare and Medicaid beneficiaries. Glasrock is deeply concerned with potential detrimental impact of Medicare cost containment measures such as the prospective payment system upon the quality of health care available to Medicare beneficiaries. Accordingly, Glasrock is willing to provide any assistance which you or your Committee might require or consider beneficial in monitoring the ongoing efficacy of the Medicare program as it adjusts to these cost containment measures. We wish to emphasize that if at any time you believe Glasrock could be of service, you and your staff feel free to contact me so we can determine if there is any way in which Glasrock can assist you.

Sincerely,

Mario V. Mirabelli

MVM:alb

Enclosure

PREPARED STATEMENT
OF
GLASROCK HOME HEALTH CARE, INC.
ON THE IMPACT OF MEDICARE'S PROSPECTIVE PAYMENT SYSTEM ON THE QUALITY OF CARE RECEIVED BY MEDICARE BENEFICIARIES

BEFORE THE
SPECIAL COMMITTEE ON AGING
UNITED STATES SENATE

SEPTEMBER 26, 1985
OCTOBER 24, 1985
NOVEMBER 12, 1985

As President and Chief Executive Officer of Glasrock Home Health Care, Inc. ("Glasrock"), and on its behalf, I hereby submit the following written testimony in connection with the ongoing oversight hearings of the United States Senate Special Committee on Aging ("Special Committee on Aging") into the impact of Medicare's prospective payment system on the quality of health care received by Medicare beneficiaries. Glasrock is a full service home health care equipment company specializing in providing respiratory therapy and durable medical equipment ("DME") to the public. Glasrock is the nation's largest provider of home health care equipment maintaining 248 outlets which serve the American public in 38 states. Glasrock services the full range of home health care consumers including Medicare and Medicaid beneficiaries.

At the outset, I would like to take this opportunity to thank the Special Committee on Aging for encouraging Glasrock to participate in this hearing through the submission of written testimony. As will be discussed more fully below, Glasrock recognizes that the prospective payment system based upon the diagnostic related group (the "PPS/DRG System") which recently has been implemented to determine the level of reimbursement for Medicare beneficiaries is an extremely important means of achieving much needed savings in Medicare expenditures. These savings are essential if the Medicare system is to remain solvent and public confidence in the system is to be maintained. These savings must not be achieved, however, at the far greater cost of compromising the health care available to Medicare beneficiaries.

Glasrock, as a corporation paying FICA taxes which serve to support the Medicare system, and as a business the success of which is dependent upon the strength of our national economy, is vitally interested in the reduction of the federal budget deficit and the continued economic and political viability of Medicare. Accordingly, Glasrock strongly supports the difficult ongoing efforts to reduce the federal budget deficit and the pressure placed upon the Medicare system by unwarranted and unreasonable increases in health care costs. Glasrock recognizes that the need to reduce Medicare expenditures was the primary factor leading to the implementation of the PPS/DRG System. Glasrock also believes, however, that because the PPS/DRG system has serious implications for vital health care services being provided to some of the most vulnerable members of our society, senior citizens, the system must be analyzed carefully against its potential impact upon Medicare beneficiaries, and in light of the socially beneficial purposes of Medicare and the American public's perception of the system's efficacy.

Based upon our review of the Special Committee on Aging's Staff Report (the "Staff Report") from the September 26, 1985 hearing, it is clear that it is precisely this analysis which the Special Committee on Aging presently in undertaking by these hearings. It is vitally important that the quality of the home health care environment be carefully considered and understood if the PPS/DRG System is to succeed in lowering Medicare expenses while continuing to provide adequate health care to older Americans. Such an understanding also will be necessary to determine if adjustments in the System are required to insure the quality of health care being provided. The PPS/DRG System will not succeed if it is treated merely as a means to lower Medicare expenditures without regard to the corresponding effect on the quality of health care. Accordingly we commend the Special Committee on Aging for its concern with, and efforts in investigating the quality of home health care available to Medicare beneficiaries. We also believe, however, that a true understanding of the home health environment cannot be achieved without an understanding of the role of, and problems facing, the DME supplier.

I read with great dismay the numerous case histories in the Staff Report of severely ill Medicare beneficiaries being discharged from the hospital into home health environments when neither the patient, nor their family members (if any), were prepared to deal with the serious health care problems which would be encountered subsequent to discharge. We at Glasrock are especially sensitive to the pressures and problems which confront both the patient discharged into the home health environment, as well as their family and friends who must provide important support and assistance if proper home health care is to be received. Glasrock also plays an important, and since the implementation of the PPS/DRG System, greatly expanded role in the provision of quality home health care to Medicare beneficiaries. Glasrock provides both DME as well as training and support personnel to instruct the DME user in the equipment's proper use, to monitor the patient's progress in connection with the equipment, and to provide vital maintenance of the equipment. Accordingly, Glasrock feels that it, and all other DME suppliers, are a vital link in the home health care continuum.

Glasrock recognizes that the current series of hearings being held by the Special Committee on Aging focus primarily upon the quality of the medical decision making processes with respect to Medicare patient discharge which are occurring under the PPS/DRG system. The case histories cited in the Staff Report vividly demonstrate the potential harm which can occur to a Medicare beneficiary when serious health care decisions are based solely upon the amount of Medicare reimbursement available to a hospital under the PPS/DRG System. Clearly it is unacceptable for discharge decisions to be made on this basis. Although Glasrock is not directly involved in the discharge decision making process, it serves a vital function if the ultimate goal of hospital discharge (i.e., the return of the patient to a home environment where adequate care can be received) by supplying the DME needed to complete the health care process in the home. Regardless of any alterations to the discharge process which may occur in the PPS/DRG System, it is clear that the role of the DME supplier in providing home health care will continue to grow. For this reason it is extremely important that Medicare beneficiaries be able to obtain quality DME and other home health services if they are to receive the health care they deserve. The ability of Medicare beneficiaries to obtain quality DME can pose as serious a health threat as early discharge from the hospital. Unfortunately, and as is discussed more fully below, certain industry and governmental developments are compromising the quality of DME available to Medicare beneficiaries. Accordingly Glasrock believes that in completely evaluating the home health environment the Special Committee on Aging should consider the problems and challenges facing DME suppliers as they attempt to contribute to the success of the PPS/DME System by fulfilling their expanding burden of providing increasing services at a time of increasing restrictions on reimbursement.

The pressures facing DME suppliers must be understood if the quality of the home health care continuum is to be analyzed correctly. Glasrock believes the issue is of significant enough importance to warrant separate hearings to which Glasrock would be willing to contribute in any way which the Special Committee or its Staff believes could be useful. Essentially, Glasrock believes that the increased role of DME (and the corresponding increased Medicare reimbursement for DME) must be viewed as a necessary and desirable result of the far greater Medicare savings which are resulting from the implementation of the PPS/DRG System. To treat the resulting increasing Medicare reimbursements to the DME supplier as a separate and distinct budget item with no apparent correlation to the savings being achieved by the PPS/DRG System, and attempt to extract even greater Medicare cost savings by restricting reimbursement for DME, is to ignore the true intent of the PPS/DRG System and frustrate its purpose. To treat the issue of DME in this manner will result in additional Medicare cost containment, but only at the far greater cost of compromising health care available to Medicare beneficiaries as well as public confidence in the the Medicare system. The cost savings measures concerning DME will only compound the problem currently under investigation by the Special Committee on Aging. The Medicare beneficiary discharged early from the hospital by the PPS/DRG System will be further handicapped in his ability to obtain quality health care at home by the restraints placed upon reimbursement for DME.

The recent implementation of the PPS/DRG System has increased dramatically the importance of home health care in the overall provision of health care to Medicare beneficiaries. In accordance with its intended purpose, the PPS/DRG System is reducing Part A Medicare reimbursements to hospitals, and is reducing the length and cost of hospital visits by Medicare beneficiaries. Since hospitals now either must provide the Medicare beneficiary with services the cost of which are within the level of reimbursement mandated by the the PPS/DRG System or absorb any cost beyond that reimbursed level, the hospitals quite frequently are discharging the patient into the home environment at an earlier period in the patient's illness. The patient so discharged, therefore, has not achieved the level of recovery, or is "sicker," than he previously would have been upon his return home. Accordingly, health care services which previously were being provided to Medicare beneficiaries in the hospital now are being provided at home at a substantial savings to the Medicare system. In fact, in many cases the determination to discharge the beneficiary and the actual discharge now occur on the same day whereas prior to the PPS/DRG System, there often was an interval of up to several days between decision and actual discharge which allowed the attending physician at the hospital to prescribe the necessary home health services and to educate the patient in their proper utilization.

Essentially, the PPS/DRG System has eliminated this home health training interval. In order to compensate for this change and insure that the patient receives the best possible home health care, the physicians and hospital staffs are insisting that DME suppliers such as Glasrock include training and other support with the home health services being provided. In other words, as a condition of referring the Medicare beneficiary, the hospitals now are requiring the DME supplier to provide the training and other support services all or much of which previously was received at the hospital. For example, Glasrock and other DME suppliers now routinely are required to provide respiratory therapists in connection with the provision of oxygen equipment at home. Hospitals often require that enteral feeding patients be provided with visiting nurse service by the DME supplier. Neither of these corollary services were within the industry's practices prior to the implementation of the PPS/DRG System, but are becoming common aspects of the full range of service provided by the home health firm.

The changing and expanding role of the DME suppliers clearly is demonstrated in the case studies which are attached as Exhibits A and B hereto. Exhibits A and B are case studies of Medicare beneficiaries actually served by Glasrock's facility in Greensburg, Pennsylvania. As you will note, in both cases Glasrock as the DME supplier was required to provide a respiratory therapist on a repeated basis and in one case also was required to provide a visiting registered nurse. In addition, these case studies illustrate the ongoing highly technical and specialized services which Glasrock must provide in order properly to service the needs of the Medicare beneficiaries. Clearly, the services of the DME supplier have become more important than ever in ensuring that Medicare beneficiaries receive adequate medical care subsequent to their discharge from the hospital.

The provision of the aforementioned additional services as well as numerous other training and support services now required because of the PPS/DRG System represents a substantial increase in the DME supplier's cost of providing services to Medicare beneficiaries. These additional costs are the foremost cause of the increase in reimbursement for Medicare Part B services. As noted above, however, these increases represent charge adjustments based on actual increased cost to the DME supplier and are not the result of unjustified increases intended merely to increase reimbursement from the Medicare system and augment profits. Fair and accurate analysis of the recent increases in home health costs mandates recognition that these increases are a necessary and desirable consequence of the PPS/DRG System, the net result of which is dramatically to reduce Medicare costs.

The effect of these increases upon our industry is evidenced by recent trends toward business failures and mergers. After a short period of rapid growth in the number of DME suppliers, substantial increases in the cost of doing business including those discussed herein have caused many smaller firms to cease operations or to be acquired by larger firms. This reduction in the number of home health firms will only lessen competition and cause more price increases in the future, and certainly is not in the best interests of the Medicare beneficiary. These additional charges have not increased Glasrock's profits, but rather, during the period 1981-1984, Glasrock's profit margin on Medicare reimbursed services has remained stable or decreased slightly. In addition we anticipate that because of other newly implemented cost containment regulations applicable to our business our profit margin on these services for 1985-1986 will decrease further.

Conclusion

Notwithstanding the foregoing the Health Care Financing Administration ("HCFA") as well as some Members of Congress believe that rising Medicare expenses for DME reimbursement should be restricted notwithstanding the effect the restrictions will have on the home health care being provided to Medicare beneficiaries. HCFA recently announced new rules effective October 1, 1985, the effect of which is to freeze Medicare reimbursement for DME during current fiscal year ending September 30, 1986, and, thereafter, to restrict increases by the Consumer Price Index. In addition, a legislative proposal currently pending before the House Energy & Commerce Committee embodies the same restrictions. A proposal currently pending before the House Ways & Means Committee would permit an increase of no more than 1% over July 1, 1984, reimbursement levels for rented DME which thereafter would be limited by the Consumer Price Index. Reagan Administration and Senate Finance Committee proposals are substantially similar to the Ways and Means measure. Glasrock believes that both the HCFA Rule and the pending legislation result from the lack of understanding that these increases are not attributable to increased profits accruing to the DME suppliers, but, rather, the result of the increased responsibilities of the DME supplier in providing home health care to Medicare beneficiaries subsequent to the implementation of the PPS/DRG System.

We again emphasize that if further and substantial erosion of the overall quality of health care available to Medicare beneficiaries is to be avoided, an accurate understanding of the dynamics of the home health care industry, and especially the role of the DME supplier must be achieved by the appropriate representatives of our federal government responsible for the quality of health care under Medicare. Only when such an understanding is achieved, will a proper balance have been reached whereby substantial Medicare savings are realized through the PPS/DRG System, while at the same time the quality of home health care available to Medicare beneficiaries is ensured through the availability of DME. We believe that the interest of the Special Committee on Aging in fully and fairly evaluating the home health continuum represents an excellent beginning in providing the Congress and the administrative agencies with the information vital to an understanding of the current home health environment. We again stress the importance of this issue and the need to expand the scope of the current hearings to encompass this matter.

EXHIBIT A

Glasrock Home Health Care

203 South Maple Avenue
Greensburg, PA 15601
412/837-3220

ASE I:

Patient M.K.

May 20, 1985 - Received order from hospital for patient M.K., who is being discharged May 21.

Diagnosis: Cerebral Vascular Accident (Stroke)
Tracheotomy
Blood Gas Level (PO_2) = 39.4 mmHg

(Normal PO_2 for a person M.K.'s age: 80-85 mmHg)

Patient required for home management of his illness the following equipment and supplies:

1) Liquid Oxygen System

-Liter flow set at 6 liters per minute, 40% concentration

-24 hour continuous oxygen therapy

-Heated, large volume nebulizer to maintain adequate humidity of tracheotomy and airways.

Additional Supplies:

Tracheotomy Cleaning Kits

Unit-dose Normal Saline

Laerdal Manual Resucitator Bag

Control III Cleaning Solution - to disinfect system components.

2) Suction Machine

-For family caregiver to suction fluids from patients tracheotomy so that breathing would not be impaired.

3) Enteral Feeding System

-Patient could not take food by mouth. A naso-gastric tube was inserted for feeding the patient a liquid nutritional formula.

BOC Health Care

203 South Maple Avenue
Greensburg, PA 15601
412 837 3220

May 21, 1985 - Equipment and supplies delivered to patient's home.

1) Our Respiratory Therapist visited the patient and family at home to instruct on the operation of the Home Oxygen System. Therapist was in the home approximately 90 minutes.

2) Our Registered Nurse visited the patient and family at home to instruct on the operation of the Enteral Feeding System. Originally, a mechanical feeding pump was ordered as a component of the system. Our nurse, after discussions with the family, determined that they could not operate such a device properly. The nurse telephoned the physician from the house, discussed her observations, and subsequently received an order by the physician to change to a manual, gravity-drip feeding system and eliminate the pump.

3) Respiratory Therapist continued to visit patient monthly to monitor his oxygen therapy.

June 25, 1985 - Patient improving. Physician changed oxygen prescription to 2 liters-per-minute for 11-12 hours per day.

1) To reduce cost-to-patient, Home Oxygen System changed from liquid oxygen to Cylinder (Gaseous) Oxygen in cooperation with the physician.

2) Our Respiratory Therapist visited patient to instruct them in new system. Continued monthly monitoring of patient.

September 7, 1985 - Patient declining. Physician changed oxygen presription to 3 liters-per-minute for 12-14 hours per day.

1) To stabilize cost-to-patient, Cylinder Oxygen System replaced with Oxygen Concentrator.

2) Our Respiratory Therapist visited patient to instruct them in new system.

203 South Maple Avenue
Greensburg, PA 15601
412 837 3220

September 20, 1985 - Family called after-hours. Patient's spouse felt that suction machine not functioning properly. Machine exchanged at 10:00 pm, (response to call - 45 minutes). Upon inspection, machine was working normally.

September 27, 1985 - Patient still declining. Physician changes oxygen prescription again. During stress, patient must increase liter flow from 3 to 7 liters-per-minute.

1) Patient's current system, the oxygen concentrator, has a maximum flow rate of 4 l.p.m. Patient put back on Cylinder Oxygen to handle increased demand.

2) Our Respiratory Therapist visited home to review new system.

Patient is stable to date.

Other Facts:

1) Our Respiratory Therapist is in weekly contact with family by telephone.

2) Family has called us after-hours and on weekends 10-12 times. Visits have been made by our staff immediately to address given situations.

3) Family is telephoned each Saturday morning to check for oxygen levels to carry through the weekend.

EXHIBIT B

Glasrock Home Health Care

203 South Maple Avenue
Greensburg, PA 15601
412 837 3220

SE II:

Patient M.L. - September 20, 1985

We were contacted by a hospital and informed that Patient M.L. would be discharged soon.
Diagnosis - Severe Chronic Obstructive Pulmonary Disease.

Patient's residence over 30 miles from our branch offices.

Equipment Ordered: Cylinder (Gaseous) Oxygen System

Prescription: 2-3 Liters-per-minute for 6-8 hours-per-day.

Hospital Discharge: Planner requested, 1) delivery pre-discharge and 2) for our Respiratory Therapist to visit family to explain Home Oxygen Therapy to family members and dispel their fears of having oxgyen in their home. Both were done this date.

September 23, 1985

1. Family contacted by hospital and informed them, without prior warning, that patient was being sent home on this day.

2. In addition, the Home Oxygen Therapy prescription was changed, without prior notification, to 8 liters-per-minute at a concentration of 35%, for 24-hour continuous oxygen therapy.

3. Additional cylinders were delivered to satisfy higher-use-prescription.

4. Our Respiratory Therapist contacted the family to discuss new settings on oxygen system.

September 28, 1985

1. To reduce patient-cost, a special high-flow capacity oxygen concentrator was ordered by our Respiratory Therapist from manufacturer. In order to keep costs contained until special system arrived, Cylinder Oxygen System was replaced with a Dual-Manifold Liquid Oxygen System with twice the volume capacity as a regular Liquid Oxygen System. This system would also prevent the danger of depleting the contents during a weekend or nighttime.

2. Our Respiratory Therapist visited the patient to explain the new system and evaluate his use of the system.

October 1, 1985

1. Liquid Oxygen System Reservoir refilled.

BOC Health Care

Glasrock Home Health Care

203 South Maple Avenue
Greensburg, PA 15601
412 837-3220

Page Two
CASE II

October 2, 1985

1. New oxygen concentrator arrived. Delivered to patient with a Cylinder Oxygen System as a back-up in the event of a power failure.

2. Our Respiratory Therapist re-visited the patient to review the instructions. Reported observations to physician as normal.

American
Psychiatric
Association

1400 K Street, N.W.
Washington, D.C. 20005
Telephone: (202) 682-6000

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January 31, 1986

Honorable John Heinz
Chairman
Special Committee on Aging
G-33 Dirksen Senate Office Building
Washington, D.C. 20510

Dear Mr. Chairman:

We very much appreciated your leadership in examining the impact of DRGs on the quality of health care. The American Psychiatric Association analysis and evaluation of psychiatric DRGs was provided to HCFA as a follow-up to the June 27-28, 1985, NIMH-HCFA Conference on Research in Progress on Extension of Prospective Payment to Psychiatric Hospitals and Exempt Psychiatric Units of General Hospitals. I thought you would be interested in having a copy.

Our study and analysis of the appropriateness of the DRG classification scheme for psychiatric patients -- based upon our examination of over 1.7 million patient records (the APA purchased a large hospital discharge data base and studied the potential impact of DRGs on psychiatric patients and inpatient psychiatric units in general hospitals) -- has concluded that the Congressional exemption of these facilities and units was and still is correct. DRGs are not adequate as a patient classification system for the mentally ill.

Please know that the preliminary findings of this study, confirmed in other independent analysis by other health and mental health organizations, justify continuation of the exclusion until a realistic alternative is found.

The Chair of the APA Task Force on Prospective Payment, Joseph English, M.D., looks forward to discussing this issue with you further in the near future. Their report concluded there was substantial inaccuracy in the psychiatric DRGs prediction of resource use, which could lead to inappropriate discharge of patients and financial risk to hospitals that treat more severe cases.

Cordially,

Jay Cutler

Jay B. Cutler
Special Counsel and Director
Division of Government Relations

American Psychiatric Association

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FINDINGS AND CONCLUSIONS OF THE AMERICAN PSYCHIATRIC ASSOCIATION

STUDY & EVALUATION OF THE MEDICARE PROSPECTIVE PAYMENT SYSTEM

-- DIAGNOSIS RELATED GROUPS AND PSYCHIATRIC PATIENTS

SEPTEMBER 1985

American Psychiatric Association

1400 K Street, N.W., Washington, D.C. 20005 Telephone: (202) 682-6000

FINDINGS AND CONCLUSIONS OF THE AMERICAN PSYCHIATRIC ASSOCIATION STUDY & EVALUATION OF THE MEDICARE PROSPECTIVE PAYMENT SYSTEM
DIAGNOSIS RELATED GROUPS AND PSYCHIATRIC PATIENTS

I. INTRODUCTION

PL 98-21 - the Social Security Amendments of 1983 - established a system of per case prospective reimbursement for hospital care for Medicare beneficiaries based on DRGs. At the time of the enactment, the question as to the appropriateness of the DRG classification scheme for psychiatric patients was drawn into focus. Set forth herein are the results of the American Psychiatric Association's (APA) analysis and evaluation of the DRG system for psychiatric patients.

Specifically, the APA's DRG study was designed to:

- Evaluate the accuracy of the DRGs as a patient classification scheme;
- Examine factors related to variation in psychiatric patient length-of-stay;
- Analyze the implications of the risks DRGs pose for some hospitals; and
- Examine the risks for psychiatric patients under a DRG payment system.

The APA views these questions as being of considerable importance because we are in an era of essentially capped expenditures for the Medicare program -- the amount of Medicare dollars spent for psychiatric care will remain the same. Therefore, the question of significance is how good the DRGs are as a mechanism to distribute limited and fixed dollar resources and what are the implications for the psychiatric treatment system if the DRG patient classification scheme is used for Medicare reimbursement of psychiatric patient care.

II. OVERVIEW OF APA STUDY

Under the direction of the APA Task Force on Prospective Payment, a data base was procured for analysis and evaluation purposes, and two advisory groups - a Technical Advisory Group and Clinical Advisory Group - were established to assist the Task Force in the conceptualizaton and conduct of the APA study effort. (The membership of each of the respective groups is set forth in Attachment 1).

The data obtained and utilized for the analysis were drawn from a large patient discharge abstract data set (Uniform Hospital Discharge Data Set (UHDDS) format) from 1195 acute care general hospitals for the years 1980-1984 (see Table 1). In addition to variables available from the UHDDS format, we were able to integrate information about hospital bed size and location by state, and whether the hospital associated with each patient discharge has a separate psychiatric or alcohol unit. This study file includes 757,000 patient discharges indicating a primary diagnoses of mental disorders or substance abuse. This patient universe includes 161,000 patient cases where Medicare was the primary payor and it is these Medicare patients which are the primary focus of this study and evaluation.

TABLE 1

DATA BASE OVERVIEW
AMERICAN PSYCHIATRIC ASSOCIATION
STUDY OF MEDICARE DRGs

- File Size: 1.7 Million Records
- Records with Primary Psychiatric Diagnoses: 757,000
- Years Covered: 1980-1984
- Total Hospitals: 1,195 Acute General Hospitals
- Psychiatric Patients where Medicare as Payor: 161,000

All data items available in the data file were reviewed for possible inclusion in the analysis (see Table 2). Frequency distributions by each variable were used to develop a summary outline of the data. These descriptive statistics were then compared to available national data (e.g., the National Center for Health Statistics and the Medical Provider Analysis and Review File (MEDPAR) of the Health Care Financing Administration) for the same time frame. Distributional analysis revealed no significant differences between the APA data and the national data across stratum of diagnoses, sex, age, and race. We were able to conclude that the patients in this study comprise a representative cross section of psychiatric patients discharged from acute care general hospitals.

TABLE 2

VARIABLES AVAILABLE FOR ANALYSIS
AMERICAN PSYCHIATRIC ASSOCIATION
STUDY OF MEDICARE DRGs

PATIENT-RELATED INFORMATION

- o Principal & Secondary Diagnoses
- o Principal Procedures
- o Age, Sex & Race
- o Admission Type & Discharge Status
- o Length of Stay
- o Total Charges
- o Payor Source

HOSPITAL-RELATED INFORMATION

- o Hospital Bed Size
- o Presence of Separate Psychiatric and/or Alcohol Unit
- o Regional Location by State
- o Case-Mix Index

The representativeness of the hospitals making up the study file was also examined. Two discrepancies, by bed size and region, were revealed when the APA study file was compared to the national distribution. These were corrected for in the analysis by appropriate statistical techniques.

In order to render the study file a more manageable size for statistical analyses, 1982 was selected as the year for analysis with 1983 reserved for testing the results of the 1982 data. The 1982 and 1983 portions of the study file represent approximately 90,000 of the 161,000 Medicare patients in the study file. Therefore, the study findings discussed are drawn from the 1982 data; confirmed by subsequent testing against the 1983 data in the APA study file. The data were trimmed of statistical outliers for all analyses discussed herein using a methodology identical to that utilized by the Health Care Financing Administration (Department of Health and Human Services).

III. ACCURACY OF DRGS AS PATIENT CLASSIFICATION SCHEME

As noted earlier, it is the question of the accuracy and the reliability of the DRG classification scheme for psychiatric patients which formed the basis for the exemption and was, therefore, the focus of APA's DRG analysis and evaluation.

It is generally agreed that, in order for the DRGs to be meaningful for payment purposes, each DRG should contain patients with a similar pattern of resource intensity and similar clinical characteristics, that is, it should be homogeneous from both a statistical and clinical viewpoint. Therefore, how well the DRGs aggregate psychiatric patients with similar treatment requirements was a central question for analysis.

The analysis protocol to determine the homogeneity of the psychiatric DRGs was relatively straightforward. First, we derived the coefficients of variation (CV) for patient length-of-stay (LOS) within each of the DRGs. As can be seen in Table 3, we found large coefficients of variation for the Medicare psychiatric patients in our data base. These CVs are comparable to those for the psychiatric patients in the MEDPAR file as well. In terms of patient LOS, the coefficients of variation for each of the DRGs are close to or greater than one. The adjusted aggregate (number of patients per DRG times the average C.V. for each DRG; summed, and averaged) across the psychiatric DRGs was 1.019. Thus, the CV analysis indicates that patients within the psychiatric DRGs have widely disparate lengths of stay (with patient LOS serving as a proxy for patient medical care needs).

The indication by the large CVs -- that the DRGs are not statistically homogeneous -- is also borne out by a probit analyses (e.g., normal equivalent deviate analysis) we undertook to more closely examine the patient distributions within each DRG. This analysis readily demonstrated that in not one of the psychiatric DRGs is there a unimodal distribution. Rather, each DRG reflected a multiplicity of different clinical groupings. At a minimum, there is a bimodal distribution for each of the DRGs and in some cases, such as DRG 430, three or more modes exist.

TABLE 3

COEFFICIENTS OF VARIATION IN THE APA STUDY FILE COMPARED TO HCFA DATA

DRG	DIAGNOSTIC GROUP	APA C.V.	HCFA C.V.
424	W/O.R. Procedure	.95	1.22
425	Acute Adj. Reaction	1.00	1.07
426	Depressive Neuroses	1.01	.94
427	Neuroses Except Depressive	.99	1.10
428	Personality Disorders	1.12	1.21
429	Organic Disturbance/Retardation	.98	1.07
430	Psychoses	.94	.95
431	Childhood Mental Disorders	1.50	1.44
432	Other Dx of Mental Disorder	1.32	1.57
MDC 19	Adjusted Total*	1.019	1.013

* Adjusted Total Does Not Reflect DRG 424.

Source: APA Data, 1982, Medicare Cases N = 33,821.

Source of National Comparison: MEDPAR Data, 1981.

The results of the CV analysis of the DRGs are not really startling when one considers that the groupings are composed of individual ICD-9-CM codes. To examine this more closely, we calculated coefficients of variation of the ICD-9-CM codes within DRGs. This analysis yielded similar results to that for the DRGs (see Table 4). As one can readily see, the variation at the individual diagnostic code level is equal to or greater than the CVs observed for the DRGs.

TABLE 4

COEFFICIENTS OF VARIATION FOR ICD-9-CM CODES

ICD-9-CM	DIAGNOSIS	C.V.
31090	NONPSYCHOT BRAIN SYN NOS	2.43
29620	DEPRESS PSYCHOSIS-UNSPEC	.82
30040	NEUROTIC DEPRESSION	1.00
31100	DEPRESSIVE DISORDER NEC	1.07
29000	SENILE DEMENTIA UNCOMP	1.97
29890	PSYCHOSIS NOS	5.53
29630	RECURR DEPR PSYCHOS-UNSPEC	.86
30000	ANXIETY STATE NOS	1.13
29530	PARANOID SCHIZO-UNSPEC	1.18
29010	PRESENILE DEMENTIA	4.79
29570	SCHIZOAFFECTIVE-UNSPEC	.94
29590	SCHIZOPHRENIA NOS-UNSPEC	.98

NOTE: The ICD-9-CM Codes Appearing Above Are for the Most Frequently Occuring Dx in MDC 19 in the APA Data Before Trimming.

SOURCE: APA Data, 1982, Medicare Cases, N = 34,188.

Conclusion: In summary, these analyses indicate that patient LOS within DRGs is far from normally distributed. Our analysis reveals that DRGs do not adequately group patients relative to their medical needs. Rather, close analysis of the psychiatric DRGs indicates that the patients within a given DRG have widely disparate lengths of stay and medical needs. Therefore, the DRGs as a classification system for psychiatric patients fail to group patients in a sufficiently meaningful way for reimbursement purposes.

IV. VARIATION IN PSYCHIATRIC PATIENT LOS

Additional analysis was undertaken to explore whether this conclusion as to the DRG's inaccuracy as a patient classification scheme was fully warranted. Specifically, we wanted to determine the extent to which the variation in patient LOS is explained by the DRGs and to more closely examine other factors that may account for variation.

Utilizing a regression analysis procedure (SAS-GLM) we analyzed the proportion of variation in patient LOS experience explained for by the DRGs (see Table 5). We found that only 5.6% of the variation in Medicare patient LOS is explained by DRGs.

TABLE 5

VARIATION IN MEDICARE PATIENT LOS
EXPLAINED BY DRG

Predictor Variable	% of Variance Explained
DRG	5.6%

Source: APA Data, 1982 Medicare MDC 19 Cases, N = 33,821.

Subsequent to this DRG-only analysis we introduced the following patient-related variables to the regression analysis:

- o Patient Age and Sex
- o Whether the Patient Left Against Medical Advice
- o Medical Complications/Comorbidity
- o Non-Operating Room Procedures

The contribution to the total variance explained (R^2) was approximately 3.3% -- bringing the total variance explained to about 8.9% (see Table 6).

TABLE 6

VARIATION IN MEDICARE PATIENT LOS EXPLAINED BY PATIENT RELATED CHARACTERISTICS

Predictor Variable	% of Variance Explained
Patient Age	.1
Patient Sex	.1
AMA Discharge	.7
Complication or Comorbidity	.8
Procedures (Non-O.R.)	1.6
Combined Effect	3.3
Combined Effect with DRGs	8.9

Source: APA Data, 1982, Medicare MDC 19 Cases, N = 33,821.

We also introduced the available hospital variables -- hospital size and presence of a unit -- to the regression analysis. The introduction of these variables led to an increase in variance explained of 1.7% (see Table 7).

TABLE 7

VARIATION IN MEDICARE PATIENT LOS EXPLAINED BY HOSPITAL CHARACTERISTICS

Predictor Variable	% of Variance Explained
Hospital Bed Size	1.2
Psychiatric Unit	.5
Combined Effect with DRGs & Patient Related Characteristics	10.6

Source: APA Data, 1982, Medicare MDC 19 Cases, N = 33,821.

The total variance explained on the basis of the regression analysis was approximately 11%. These results are consistent with the work of other researchers who have examined the explanatory power of the DRGs with respect to variation in patient experience. The large pool of unexplained variance - 89% - confirms the results of the CV and probit analyses -- the DRGs are inadequate as a psychiatric patient classification scheme for reimbursement purposes.

V. HOSPITALS AT RISK UNDER DRGs

While analysis clearly indicates that there is a poor relationship between a DRG payment and the resources potentially needed for patient treatment, the question as to the implications of the DRG's inadequacies as a classification scheme, if used for reimbursement purposes, remains. In our view, the inadequacies of the DRGs as a classification scheme for reimbursement places some hospitals at undue financial risk. This hospital risk factor has several negative implications for patient care.

The DRG analysis discussed above suggests that average patient treatment requirements (as measured by patient LOS) for a particular DRG are unpredictable. Therefore, the typical hospital under a DRG scheme will be overpaid or underpaid for individual patient discharges. This translates into financial uncertainty for a hospital. The critical issue for the hospital, therefore, is what happens on balance, that is, whether overpayments and underpayments cancel each other.

The extent of risk each hospital is exposed to under a DRG payment plan -- where there is significant variation in the patient groupings -- will be mitigated to the extent each hospital; 1) treats a volume of patients sufficient to make an average payment system work; and 2) receives a random draw of psychiatric patients. The APA analysis focused on the second proposition -- whether or not hospitals have an equal likelihood of drawing high cost patients.

A fundamental assumption behind DRGs was that all hospitals will receive a random draw of patients (i.e., both high and low cost patients). To the extent this assumption is warranted, the risks associated with the wide variation observed for the DRGs is mitigated, provided hospitals treat the requisite volume of patients needed to make a payment scheme based on averages work. If not, then the DRG reimbursement system may systematically penalize or reward either individual hospitals or classes of hospitals.

Specific investigation and analysis of our data on this point indicates that the distribution of high cost patients (e.g., outliers) is systematic rather than random. This result indicates that risks discussed above are real indeed.

Specifically, we undertook an analysis of the outlier patient experience (i.e., distribution of high cost patients by hospital) in the APA study file. We defined outliers on the basis of length of stay as they are in the final Department of Health and Human Services regulations implementing the Medicare DRG program.

As shown in Table 8, 56% of all hospitals in the study file do not have a single patient outlier case. 11% of the hospitals have total patient outlier experience which is 1-4% of total caseload and 13% of all hospitals, accounting for 77% of all outlier patients, have an outlier experience which totals 15% or more of their patient caseload.

TABLE 8

DISTRIBUTION OF OUTLIER CASES BY HOSPITALS
(ALL HOSPITALS)

Outliers As % Of All Patients	% of Hospitals by Level of Outlier Patient Load	% of Total Outlier Cases
30%+	3.9%	36.2%
20-29%	4.8	21.5
15-19%	4.8	18.9
10-14%	6.1	11.7
5-9%	13.6	7.5
1-4%	11.1	4.2
No Outlier	55.7	0
	100.0	100.0

Source: APA Data, 1982 Medicare Cases, N = 43,227.

Considering only those hospitals with psychiatric units (see Table 9), 32% account for 80% of total outlier experience for psychiatric units in the study file. The average outlier experience for these hospitals exceeds 15% of total caseload and many show an outlier patient experience in excess of 30%.

TABLE 9

DISTRIBUTION OF OUTLIER CASES BY HOSPITALS
(HOSPITALS WITH PSYCHIATRIC UNITS)

Outliers As % Of All Patients	% of Hospitals by Level of Outlier Patient Load	% of Total Outlier Cases
30%+	6.5%	32.9%
20-29%	13.4	29.9
15-19%	12.8	18.3
10-14%	12.4	12.9
5-9%	22.6	4.3
1-4%	8.6	2.7
No Outliers	23.7	0
	100.0	100.0

Source: APA Data, 1982 Medicare Cases, N = 43,227.

This systematic distribution of outlier patients indicates that the assumption behind DRGs of high cost patients, in this case - psychiatric patients, being randomly distributed is not supportable. The problem of a few hospitals receiving a disproportionate share (and the resultant financial penalities) of high cost patients is indeed quite real. The imposition of the DRG reimbursement system would be unfair to these hospitals and they would be at considerable financial risk if they were to continue their present caseload mixes. These hospitals, therefore, would face undue financial penalties unless they undertook a management response to lessen their high cost patient load. A management response of this sort (for reasons more fully elaborated below) would likely create serious problems for patient care. In our view, hospitals are not likely to be moderate in their response. In order to be "safe", they will have to overrespond to some degree. Therefore, the likelihood of patients to get hurt is greater.

VI. PATIENTS AT RISK

The financial risks which DRGs create for some hospitals have important implications for psychiatric patient care. And, as an association of medical professionals, this is where our ultimate concern with the DRG payment scheme rests -- patient care.

Specifically, the uncertainty with which hospitals are presented, due to the inadequacy of the DRG classification scheme (as evidenced by the high CVs and low R^2), supports incentives for hospitals to favor low-cost over high-cost patients. Therefore, the possibility that hospitals will or can manipulate their case-mix to decrease the uncertainty of financial loss must be considered.

To the extent characteristics associated with high cost patients are randomly distributed and not identifiable a priori, the opportunity for hospitals to selectively admit/discharge patients is minimized.

There are three potential categories of risk to patients under the DRG scheme:

- First, Admission Policies and Practices - can hospitals selectively admit high (or low) cost patients?
- Second, Patient Treatment Restrictions During Hospital Stay; and
- Third, Inappropriate Discharge Policies & Practices

With respect to admissions, we must ask whether there is a potential for hospitals to selectively admit patients. That is, are there characteristics associated with high cost patients which are observable at the time of admission?

The regression analysis discussed above suggested that a number of patient related variables were somewhat significant in explaining patient LOS variation. On balance, this analysis reveals that a portion of the unexplained differences in patient treatment requirements is not entirely random. We were able to improve R^2 to 11% from 5.6%. The potential effects of this are negative with respect to patient care in that this suggests that hospitals can to some extent in fact select, receive and/or recruit high or low cost patients on the basis of readily observable characteristics.

Obviously, these variables/characteristics could be incorporated into the DRG classification scheme and thereby be recognized and the payment amount adjusted accordingly. This would offset the incentive to select or avoid patients on the basis of these characteristics.

However, even if these variables were incorporated, the extent of the variation explained by the psychatric DRGs would not exceed 11%. In our view, this still has insufficient explanatory power to establish a needed linkage between DRG payment and patient resource utilization. More importantly, this large pool of unexplained variance again raises the question as to whether high/low cost patient characteristics are random or systematic thereby enabling hospitals to manage case-mix beyond the variables recognized by the reimbursement system.

While we do not have data to directly explore and provide definitive analysis as to the remaining pool of unexplained variance, we did address this possibility with our Clinical Advisory Group. After careful consideration of this matter, they indicated to us that critical and readily determinable patient cost characteristics would include: involuntary status, number of prior hospitalizations, functional status at time of admission, quality of existing family and other support systems, and diagnostic uncertainty.

Their considerations suggest that there are in fact readily identifiable factors which account for variation in patient LOS. Obviously, these variables are not within the currently available data sets and could not be incorporated into a per case reimbursement system. So even with an improved DRG scheme, the ability to selectively manage case mix could be realized and high cost patients would face potential discrimination in accessing care.

While the danger will vary with the strength of a particular hospital's profit motivation, it will obviously increase as the financial pressures on a hospital escalate -- as in fact will be the case for many hospitals as national DRG reimbursement rates become reality.

It is also important to point out that selective admissions by any group of hospitals places other hospitals at risk insofar as patients not admitted at one site will likely be referred elsewhere.

Public policy in the past 30 years has sought to emphasize alternative care to state hospitals for psychiatric patients, especially care and treatment in general hospitals. There is the danger of reversing that policy by implementing DRGs for psychiatric patients in all general acute care hospitals.

The second area of patient risk is the potential for the DRG payment scheme to operate as a restriction on treatment once in the hospital. Specifically, the system by design is intended to work on an averaging basis. That is, there are patients whose total hospital stay will cost more than the stipulated payment amount. However, this deficit will be offset by cases treated where the hospital shows a surplus.

Evidence, however, is accumulating that the DRG payment amounts and the associate patient length of stay is not being regarded as an average, rather it is being regarded as a normative upper limit on a patient's total hospital stay.

An evaluation (undertaken for the APA) of the impact of New Jersey's DRG based system on inpatient psychiatric units within general hospitals bears this out. Respondent-interviewees to this survey study indicated that the average length of stay for a given DRG was as a practical matter viewed as the upper limit for patient length of stay. In their words "the effective length of stay limits by DRG category have been internalized by the physicians." As they noted, admission decisions are being made not by diagnoses but by anticipated length of stay and by anticipated placement potential at the time of discharge.

Where physicians feel that a patient cannot be effectively treated and released with the prescribed length of stay, the patient is admitted for a two-three day assessment and then transferred to an inpatient setting outside the prospective payment system.

In sum, our findings from this study bears out APA's concerns about changed admisson and discharge practices under the financial incentives established by DRGs. In brief, the findings indicate that in the view of both administrators and psychiatrists, "admission, discharge, and referral policies and practices have been key to the psychiatric unit's survival under DRGs."

The third area of patient risk concerns the possibility of inappropriate patient discharge, i.e., would there likely be inappropriate discharge practices? Clearly, the system establishes an incentive to discharge, therefore, the question as to capacity of other treatment centers to receive new discharges is appropriate.

Underlying this issue is the question of whether post-hospitalization care resources for psychiatric patients are as available and adequate as they are for general medical patients? The patients we are concerned with are those who would be discharged from acute hospitals to other facilities because they still need care, albeit less intensive treatment and/or custodial care.

Traditional alternative care sites and resources available (for which Medicare pays) for placement after discharge from an acute facility include SNFs, and home health resources. However, present occupancy rates for those facilities at present are very high - 93% nationally. And, admissions criteria have tightened considerably. SNFs in general are shying away from admission of more difficult medical patients and it has always been harder to discharge mental patients to SNFs.

Indeed, studies illustrate and confirm that there are restricted alternative placement options for psychiatric patients and that the reason many patients have continued stays in hospitals is that suitable alternate care sites are not available.

Again, as the Medicare PPS system tightens fiscally, the pressure to discharge will be greater. With the present scarcity of appropriate alternative care resource to rely on for post-hospital placement of psychiatric patients, implementation of DRGs suggests that patients will be discharged without appropriate alternate care settings. In fact, the suggestion is that many may add to the already burgeoning numbers of the homeless. The homeless mentally ill represent a major public health problem. The current DRG approach, if implemented, would make thousands of psychiatric patients at risk for inappropriate discharge and for increased homelessness.

SUMMARY

In summary then, our analysis of the psychiatric DRGs indeed confirms that they are inadequate as a classification scheme for prospective payment. Implementation of the DRGs for psychiatric patients would have several undesirable outcomes:

- many hospitals would be placed at undue financial risk because high cost patients are systematically concentrated in certain hospitals.
- many patients are placed at undue clinical risk because the DRG system would lead to inappropriate admission, transfer and discharge.

Therefore, the conclusion of the American Psychiatric Association's DRG analysis and evaluation is that implementation of a patient related case based reimbursement system would not be appropriate at this time.

Further research on prospective payment methodologies for psychiatric patients should be conducted to develop appropriate alternatives to the DRG for implementation.

ATTACHMENT 1

THE TASK FORCE ON PROSPECTIVE PAYMENT OF THE AMERICAN PSYCHIATRIC ASSOCIATION

Joseph T. English, M.D.; Chairman
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Richard Bridburg, M.D.
Paul Fink, M.D.
Frank Rafferty, M.D.
Donald Scherl, M.D.
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